Department of Health

For the Year Ended
June 30, 1998

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June 14, 1999

The Honorable Don Sundquist, Governor
and
Members of the General Assembly
State Capitol
Nashville, Tennessee 37243
and
The Honorable Fredia S. Wadley, M.D., Commissioner
Department of Health
Cordell Hull Building, 426 Fifth Avenue North
Nashville, Tennessee 37247

Ladies and Gentlemen:

We have conducted a financial and compliance audit of selected programs and activities of the Department of Health for the year ended June 30, 1998.

We conducted our audit in accordance with generally accepted government auditing standards. These standards require that we obtain an understanding of management controls relevant to the audit and that we design the audit to provide reasonable assurance of the Department of Health's compliance with the provisions of laws, regulations, contracts, and grants significant to the audit. Management of the Department of Health is responsible for establishing and maintaining internal control and for complying with applicable laws and regulations.

Our audit disclosed certain findings which are detailed in the Objectives, Methodologies, and Conclusions section of this report. The department's administration has responded to the audit findings; we have included the responses following each finding. We will follow up the audit to examine the application of the procedures instituted because of the audit findings.

We have reported other less significant matters involving the department's internal control and/or instances of noncompliance to the Department of Health's management in a separate letter.

Sincerely,

John G. Morgan
Comptroller of the Treasury

JGM/ms
98/092

State of Tennessee

Audit Highlights

Comptroller of the Treasury — Division of State Audit

Financial and Compliance Audit
Department of Health
For the Year Ended June 30, 1998

AUDIT SCOPE

We have audited the Department of Health for the period July 1, 1997, through June 30, 1998. Our audit scope included those areas material to the Tennessee Comprehensive Annual Financial Report for the year ended June 30, 1998, and the Tennessee Single Audit Report for the same period. These areas include the Medical Assistance Program (Medicaid/TennCare); the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); the Block Grant for Prevention and Treatment of Substance Abuse; and Federal Programs—Nonspecific. In addition to those areas, our primary focus was on management's controls and compliance with policies, procedures, laws, and regulations in the areas of contracts, supplemental pay, revenue, contingent and deferred revenue, and utilization of the Department of Finance and Administration's STARS grant module to record the receipt and expenditure of federal funds. The audit was conducted in accordance with generally accepted government auditing standards.

AUDIT FINDINGS

Department of Health and Department of Mental Health and Mental Retardation Merged in the Absence of Legislative Authority

In absence of legislative authority, the Department of Health and the Department of Mental Health and Mental Retardation have effectively merged departmental functions (page 8).

TennCare Eligibility Verification Procedures Not Adequate**

For the past four years TennCare has failed to implement effective eligibility verification procedures. This finding will be reported as a repeated material internal control weakness in the 1998 Tennessee Single Audit Report (page 17).

TennCare-Related Activities at the Department of Children's Services Not Monitored*
TennCare has not monitored TennCare-related activities at the Department of Children's Services to ensure the accuracy and allowability of billings from that department despite its numerous, serious compliance and internal control problems. TennCare paid approximately $101 million in reimbursement claims to the Department of Children's Services. This finding will be reported as a material internal control weakness in the 1998 Tennessee Single Audit Report for the second year (page 20).

TennCare Management Information System Lacks Necessary Flexibility and Internal Controls
Management of the Bureau of TennCare has failed to address critical information system internal control issues. As evidenced by the number of new and repeat findings, management of the department has not made internal control a priority (page 23).

Controls Over Access to the TennCare Management Information System Were Weak and Inadequately Documented
The Director of Information Services is responsible for but has not implemented adequate TennCare Management Information System (TCMIS) access controls. Existing controls are not adequately documented. These weaknesses will be reported as a material internal control weakness in the 1998 Tennessee Single Audit Report (page 26).

TennCare's Accounts Receivable System Was an Impediment to Collection of Cost Settlements and Federal Financial Reporting*
Incorrect information in the Medicaid Accounts Receivable Recoupment System was used to prepare federal expenditure reports and has caused delays in collecting provider cost settlements (page 33).

Certain Providers Not Paid in accordance With Departmental Rules**
TennCare sometimes pays more for Medicare deductibles than departmental rules allow (page 35).

Processing of "Professional Cross-Over" Claims Still Needs Improvement*
The TennCare Management Information System has not been modified to detect third-party resources on Medicare professional cross-over claims and bureau staff did not routinely perform manual tests to ensure these claims are paid correctly (page 36).

Over $6 Million Paid on Behalf of Deceased Enrollees
TennCare failed to identify approximately 14,000 deceased enrollees and paid over $6 million in capitation payments on their behalf (page 37).

Federal Funds Used to Pay Health Care Costs of Incarcerated Youth*
TennCare made payments totaling at least $571,880.03 for juveniles in the youth development centers. Under federal regulations, the state, not the federal government, is responsible for the health care costs of juvenile and adult inmates (page 41).

TennCare Management Information System Not Updated Timely to Process Department of Mental Health and Mental Retardation Claims
TennCare management failed to process the system change request to update the procedure codes and the payment rates in the TennCare Management Information System. This caused the Department of Mental Health and Mental Retardation to use state funds to reimburse providers (page 42).

The Director of Information Services Did Not Provide Information for the Audit Timely
The Director has not always provided the auditors with requested TennCare Management Information System information timely nor demonstrated a full understanding of and concern for the objectives of the audit (page 43).

ADP Risk Analysis and System Security Review Program Not Established*
TennCare still does not have a coordinated program for ADP (automated data processing) risk analysis and security system review of the TennCare Management Information System, as required by the federal grantor (page 46).

Approximately $55,000 in Federal Matching Funds Lost
Because TennCare failed to identify incarcerated youth, TennCare lost approximately $55,000 in federal matching funds for payments made to behavioral health organizations (page 47).

Millions in State Funds Remitted to Federal Government Because of Uncollected Provider Cost Settlements**
Because TennCare still fails to collect Medicaid cost settlements from providers, state funds ($11.8 million as of November 1998) were used to pay the federal portion of the cost settlements. The federal grantor requires states to remit the federal share (approximately two-thirds) within 60 days of settlement, whether or not the state has collected the amounts due from the providers (page 48).

Cross-over Provider and Nursing Home Application Information Not Adequately Verified and the Department of Children's Services Not Monitored to Ensure Eligibility of its TennCare Providers*
For a majority of the fiscal year TennCare failed to establish procedures for the verification of provider information upon enrollment or procedures for updating provider files. TennCare also has not monitored to ensure the service providers used by the Department of Children's Services are eligible to participate in TennCare (Medicaid) (page 50).

Eligibility of Supplemental Security Income (SSI) Recipients Not Monitored
Because TennCare does not effectively monitor the eligibility of SSI recipients, TennCare made improper payments on behalf of an SSI recipient who had become ineligible for TennCare (page 52).

Inappropriate Type of Agreement Used for Medical Education Payments*
Instead of abiding by the Rules of the Department of Finance and Administration and establishing multi-year grant contracts for graduate medical education payments, TennCare entered into five-

year memoranda of understanding with the four medical schools in the state. TennCare did not obtain signed approval from the Comptroller of the Treasury for the agreements (page 54).

Graduate Medical Schools Not Monitored by TennCare

TennCare has not monitored the graduate medical schools to ensure that requirements related to graduate medical education payments (approximately $48 million in fiscal year 1998) are met, nor has TennCare advised the graduate medical schools of the audit requirements of subrecipients (page 55).

Policies and Procedures for Accounts Receivable and Accrued Liabilities Need Improvement

TennCare's policies and procedures for accounts receivable and accrued liabilities are not adequate. Because of these inadequacies, numerous deficiencies in TennCare's accounts receivable and accrued liabilities records were noted (page 57).

Revision of TennCare's Rules Needed**

Several departmental rules governing TennCare were inconsistent with TennCare's practices or did not address certain practices (page 59).

Inappropriate Reimbursement to Department of Children's Services for Employees on Administrative Leave With Pay

TennCare inappropriately reimbursed the Department of Children's Services for two caseworkers' salaries while they were on administrative leave with pay for nine months resulting from disciplinary actions (page 60).

Allowable Rates for TennCare Mental Health Services Improperly Raised**

As a condition of the TennCare waiver, the state was allowed to continue paying for mental health services on a fee-for-service basis at the rates in existence prior to TennCare. During fiscal year 1995, however, the allowable amount for mental health services was raised for inflation. TennCare has not provided written approval from the Health Care Financing Administration for this action (page 62).

Late Return of Medicaid Refunds to the Federal Government Since Fiscal Year 1994**

Recoveries from third parties were not used to promptly reduce federal participation (page 63).

Weak Controls Over TennCare Manual Checks Since 1994**

Weaknesses in manual check procedures pertaining to poor segregation of duties and the reconciliation of issued checks and paid checks were noted. Manual checks totaled approximately $315 million in fiscal year 1998 (page 65).

Subgrantees Not Adequately Monitored**

As noted in the six prior audits, the department's subgrantees are not adequately monitored. Subgrantee audit reports were not received timely, and audit exceptions, including questioned costs, noted in the reports were not followed up or resolved timely (page 67).

Inadequate Revenue Controls**
Department personnel at various locations do not restrictively endorse checks immediately upon receipt; prepare receipts or listings of cash received; adequately segregate duties; or reconcile related records, receipts, and reports (page 70).

Improper Employer-Employee Relationships**
For the past decade, the department has established improper employer-employee relationships through contracts with community services agencies, human resource agencies, and other nonprofit organizations (page 71).

Inadequate Contract Controls
The department failed to approve contracts before the beginning of the contract period (page 73).

* This finding is repeated from the prior audit.
** This finding is repeated from prior audits.

PAST FINDINGS NOT ACTED UPON BY MANAGEMENT

Draw Down and Use of Indirect Cost Funds
The Department of Health has not fully used the departmental indirect cost allocation plan for the recovery of indirect costs from block grants. Management uses eligible indirect costs for program expenditures and spends a large portion of previously recovered indirect costs for program services (page 4).

Administrative Controls for the Nursing Home Resident's Grant Assistance Program
The Department of Health has not established adequate administrative controls over the Nursing Home Resident's Grant Assistance Program to ensure participant eligibility and contractor performance, nor has the department set per diem limits (page 5).

Supplemental Pay
The Department of Health, without authorization, has allowed certain employees to receive supplemental pay from the counties employing them. Section 68-2-603, *Tennessee Code Annotated*, states that county health directors and county health officers "shall have compensation paid, all or in part, by the department of health." However, there is no provision in the law granting authority for supplemental pay to employees other than county health directors and county health officials (page 5).

Audit Report
Department of Health
For the Year Ended June 30, 1998

TABLE OF CONTENTS

TABLE OF CONTENTS (CONT.)

TABLE OF CONTENTS (CONT.)

TABLE OF CONTENTS (CONT.)

Department of Health
For the Year Ended June 30, 1998

INTRODUCTION

POST-AUDIT AUTHORITY

This is the report on the financial and compliance audit of the Department of Health. The audit was conducted pursuant to Section 4-3-304, *Tennessee Code Annotated*, which authorizes the Department of Audit to "perform currently a post-audit of all accounts and other financial records of the state government, and of any department, institution, office, or agency thereof in accordance with generally accepted auditing standards and in accordance with such procedures as may be established by the comptroller."

Section 8-4-109, *Tennessee Code Annotated*, authorizes the Comptroller of the Treasury to audit any books and records of any governmental entity that handles public funds when the Comptroller considers an audit to be necessary or appropriate.

BACKGROUND

The mission of the Department of Health is to promote, protect, and restore the health of Tennesseans by facilitating access to high-quality preventive and primary care services. To fulfill this mission, the department comprises eight functional sections: Executive Administration; Office of Budget and Finance; Bureau of Information Systems; Office of Health Licensure and Regulations; Bureau of Alcohol and Drug Abuse Services; Bureau of Health Services; Policy Planning and Assurance; and Bureau of TennCare.

One of the department's many responsibilities is to provide overall direction to, coordination of, and supervision for the state and local health departments to enable them to meet the health needs of the state's citizens. The department ensures the quality of medical resources available in the state through the regulation, certification, and licensure of health professionals and health care facilities. The central office works in coordination with four rural and six metropolitan regional offices and 95 county health departments to provide services which protect and promote health and prevent disease and injury. The department also works to improve access to quality health care services in underserved areas of the state and to underserved populations. To decrease the incidence and prevalence of alcohol and other drug abuse and dependence, the department coordinates prevention, treatment, and rehabilitation services. The department is also responsible for preserving and issuing copies of all vital records.

The Bureau of TennCare administers the TennCare program, the state's managed health care program for eligible low income, disabled, uninsurable, and uninsured individuals. TennCare

was implemented in January 1994 after the state obtained a waiver from the federal Health Care Financing Administration which allowed the state to replace its basic Medicaid program (Medical Assistance Program) with a managed care system. The TennCare Partners managed care program, implemented in July 1996, provides mental health and substance abuse treatment services to TennCare recipients. The managed care organizations (MCOs) and behavioral health organizations (BHOs) the department contracts with pay providers for the delivery of health care services.

The Bureau of TennCare also is responsible for administration of the state's Medicaid programs for long-term care and home- and community-based services, as well as the department's contract with the Department of Children's Services for case management and children's therapeutic intervention services. In addition, TennCare pays "Medicare cross-over" medical claims on behalf of recipients who are eligible for both Medicare and Medicaid.

AUDIT SCOPE

We have audited the Department of Health for the period July 1, 1997, through June 30, 1998. Our audit scope included those areas material to the Tennessee Comprehensive Annual Financial Report for the year ended June 30, 1998, and to the Tennessee Single Audit Report for the same period: the Medical Assistance Program (Medicaid/TennCare); the Special Supplemental Nutrition Program for Women, Infants, and Children; the Block Grant for Prevention and Treatment of Substance Abuse; and Federal Programs—Nonspecific. In addition to those areas, our primary focus was on management's controls and compliance with policies, procedures, laws, and regulations in the areas of contracts, supplemental pay, revenue, contingent and deferred revenue, and utilization of the Department of Finance and Administration's STARS grant module to record the receipt and expenditure of federal funds. The audit was conducted in accordance with generally accepted government auditing standards.

PRIOR AUDIT FINDINGS

Section 8-4-109, *Tennessee Code Annotated*, requires that each state department, agency, or institution report to the Comptroller of the Treasury the action taken to implement the recommendations in the prior audit report. The Department of Health filed its report with the Department of Audit on December 31, 1998. A follow-up of all prior audit findings was conducted as part of the current audit.

RESOLVED AUDIT FINDINGS

The current audit disclosed that the Department of Health has corrected previous audit findings concerning WIC voucher reconciliation procedures; grant payroll cost reallocation and drawdown procedures; recording of grant-funding information in state property records; subcontracts for TennCare Outreach service; and contracts with community services agencies.

REPEATED AUDIT FINDINGS

The prior audit report also contained findings concerning

- TennCare eligibility verification procedures;
- monitoring of TennCare-related activities at the Department of Children's Services;
- the Medicaid Accounts Receivable Recoupment System;
- providers not paid in accordance with departmental rules;
- Medicare "professional cross-over" claims processing;
- payments for ineligible incarcerated youth;
- ADP risk analysis and system security review;
- uncollected cost settlements;
- monitoring and verification of providers;
- the type of agreement for medical education payments;
- departmental rules;
- the intent of grant requirements;
- Medicaid refunds;
- controls over manual checks;
- monitoring of subgrantees;
- revenue procedures and controls;
- employer-employee relationships.

These findings have not been resolved and are repeated in the applicable sections of the report.

PAST FINDINGS NOT ACTED UPON BY MANAGEMENT

Prior audits of the Department of Health have contained findings concerning the drawdown and use of indirect cost funds, implementation of effective controls in the Nursing Home Resident's Grant Assistance Program, and supplemental pay.

Draw Down and Use of Indirect Cost Funds

The Department of Health has not fully used the departmental indirect cost allocation plan for the recovery of indirect costs from block grants. Management uses eligible indirect costs for program expenditures and spends a large portion of previously recovered indirect costs for program services.

The department enters into an annual agreement with the Division of Cost Allocation in the U. S. Department of Health and Human Services specifying the terms of the indirect cost allocation plan. The plan identifies departmental, bureau, divisional, and statewide indirect costs. The departmental, bureau, and divisional indirect costs are those incurred at a particular level for a common purpose, which benefit more than one program, function, or activity, and therefore are not directly assignable to a single program, function, or activity. Statewide indirect costs are the costs of central governmental services distributed through the statewide cost plan that are not otherwise treated as direct costs. Using the indirect cost allocation plan, the department can allocate total indirect costs by bureau or by division.

When indirect costs are not systematically drawn as a part of the program's operating costs, they are, in effect, hidden and must be paid from other sources. Although the allocation of indirect costs may actually shift the use of available federal funds from program operations to administrative overhead, the allocation is essential to present fairly the costs of administering the programs. Likewise, when earned indirect costs are used to fund program services, the true level of state expenditures incurred to fund the program is hidden, and state funds are used to fund activities at the departmental level. The decision whether additional state funds should be used for federal programs is more appropriately addressed through the legislative budget process than by each department.

Management has concurred with the finding, stating that the department's policy is to maximize the utilization of all available federal grant dollars and that the budget is predicated and reflective of these efforts. Furthermore, management has stated that any policy or procedural change requiring indirect cost funds to be used solely for administrative expenditures would necessitate a budget reorganization within the department that would have to be approved by the Commissioner of Finance and Administration and the legislature through the Appropriation Request process. However, the Department of Health has not revised its budget to address this issue, pending an official F&A Policy or directive to do so. Procedures have been implemented that will ensure recognition of the true level of state expenditures incurred to fund a program with federal funding. For any grant with an ending date subsequent to 7-1-98, indirect cost earned will be recognized in the State's accounting system (STARS) and identified as "state" funded if federal funds are not drawn.

Administrative Controls for the Nursing Home Resident's Grant Assistance Program

The Department of Health has not established adequate administrative controls over the Nursing Home Resident's Grant Assistance Program to ensure participant eligibility and contractor performance, nor has the department set per diem limits.

The program's intent is to provide a small amount of assistance to nursing home residents whose care is not paid by a state or federal program and who are income-eligible.

A private contractor is responsible for maintaining a systematic process to provide financial support for eligible individuals. However, neither the department nor the contractor verifies the accuracy of information on the applications or on the documents each nursing home completes to certify the number of days residents did not receive other assistance and to report the average per diem expense. In addition, the department does not monitor the program contractor.

If patient eligibility and contractor performance are not monitored, funds could be disbursed to ineligible participants.

Management concurred in part with the finding, stating that as the program was planned and designed, the department believed certain controls would not be cost-effective nor reasonable. Management also stated that although there are some very broad eligibility requirements in the law establishing this program, certain other financial eligibility information verification is left to the discretion of the department. When designing the program, the department chose not to further verify participant eligibility or the accuracy of information reported by nursing homes. Management agreed that the department could develop and implement procedures to more accurately verify participant eligibility and the accuracy of information reported by nursing homes, but stated that it was not appropriate to do so particularly in the early stages of developing the program, given the population involved, the intent of the program, and the relatively small grant amounts available. Management said the department would look at this situation further to determine if additional, more formal procedures were needed to adequately monitor the program contractor. The department is working with the program contractor to determine if procedures can be implemented to monitor Grant payments for eligibility.

Supplemental Pay

The Department of Health, without authorization, has allowed certain employees to receive supplemental pay from the counties employing them. Section 68-2-603, *Tennessee Code Annotated*, states that county health directors and county health officers "shall have compensation paid, all or in part, by the department of health." However, there is no provision in the law granting authority for supplemental pay to employees other than county health directors and county health officers.

Although the Department of Health has concurred with this repeat finding, its position until 1996 was to allow no new unauthorized employees to receive supplemental pay, claiming that attrition would correct the situation. In 1996, however, the department increased the positions. Of the positions added in 1996, only two were unauthorized. These two positions

were removed in 1996 and new procedures were implemented to prevent the addition of unauthorized employees to the supplemental pay listing. No new positions were added in 1997 or 1998.

OBJECTIVES, METHODOLOGIES, AND CONCLUSIONS

AREAS RELATED TO TENNESSEE'S COMPREHENSIVE ANNUAL FINANCIAL REPORT AND SINGLE AUDIT REPORT

Our audit of the Department of Health is an integral part of our annual audit of the Comprehensive Annual Financial Report (CAFR). The objective of the audit of the CAFR is to render an opinion on the State of Tennessee's general-purpose financial statements. As part of our audit of the CAFR, we are required to gain an understanding of the state's internal controls and determine whether the state complied with laws and regulations that have a material effect on the state's general-purpose financial statements.

Our audit of the Department of Health is also an integral part of the Tennessee Single Audit which is conducted in accordance with the Single Audit Act, as amended by the Single Audit Act Amendments of 1996. The Single Audit Act, as amended, requires us to determine whether

- the state complied with rules and regulations that may have a material effect on each major federal financial assistance program, and
- the state has internal control to provide reasonable assurance that it is managing its major federal award programs in compliance with applicable laws and regulations.

We determined the following areas within the Department of Health were material to the CAFR and to the Single Audit Report: the Medical Assistance Program (Medicaid/TennCare); the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); and the Block Grant for Prevention and Treatment of Substance Abuse (SAPT).

To address the objectives of the audit of the CAFR and the Single Audit Report, as they pertain to these three major federal award programs, we interviewed key department employees, reviewed applicable policies and procedures, and tested representative samples of transactions.

We have audited the general-purpose financial statements of the State of Tennessee for the year ended June 30, 1998, and have issued our report thereon dated January 25, 1999. The opinion on the financial statements is qualified. Because of the unprecedented nature of the Year 2000 issue, its effects and the success of related remediation efforts will not be fully determinable until the Year 2000 and thereafter. The Tennessee Single Audit Report for the year ended June

30, 1998, will include our reports on the schedule of expenditures of federal awards and on internal control and compliance with laws and regulations.

The audit of the department revealed the following findings in areas related to the CAFR and the Single Audit Report:

- Management of the department needs improvement as discussed in finding one.
- The TennCare program had significant weaknesses and needs improvement as discussed in findings two through 25.
- We had no findings concerning the overall administration of the Special Supplemental Nutrition Program for Women, Infants, and Children or the Block Grant for Prevention and Treatment of Substance Abuse, although we did note weaknesses in monitoring as noted in finding 26.

MANAGEMENT OF THE DEPARTMENT

Our primary objective was to evaluate the control environment of the department. Top management is responsible for establishing an effective control environment, which is the foundation for all other components of internal control: risk assessment; control activities; information and communication; and monitoring. Statement on Auditing Standards Number 78 (SAS 78) "Consideration of Internal Control in a Financial Statement Audit: An Amendment to SAS No. 55" states

> The control environment sets the tone of an organization, influencing the control consciousness of its people. It is the foundation for all other components of internal control, providing discipline and structure.

SAS 78 lists the following "control environmental factors"

- integrity and ethical values;
- commitment to competence;
- management's philosophy and operating style;
- organization structure; and
- assignment of authority and responsibility.

We determined whether management has established an effective control environment. Specifically, we determined if management had established an appropriate organizational structure including sound and clearly drawn lines of authority and responsibility. We also determined if management had set the proper "tone at the top," including whether management had recognized the importance of and made significant progress toward resolving the internal control deficiencies

reported in prior audits. In addition, we considered the nature and number of new findings that resulted from the current audit.

We determined that the Department of Health and the Department of Mental Health and Mental Retardation had effectively merged in the absence of legislative authority. (See finding 1 for more information about the merger of the departments.). We also determined that the control environment and the department's management could be more effective and responsive. This will be reported to management in a separate letter

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1. The Department of Health and the Department of Mental Health and Mental Retardation have effectively merged in the absence of legislative authority

Finding

In the absence of legislative authority, the Department of Health (Health) and the Department of Mental Health and Mental Retardation (DMHMR) have merged departmental functions effectively abolishing DMHMR as an independent department. In February 1997, the administration proposed to transfer the functions, duties, responsibilities, and authority of the DMHMR to Health in bills filed in the General Assembly (Senate Bill 1925, House Bill 1827). The bills were considered during the 1998 legislative session and subsequently withdrawn after lengthy discussions and testimony from administration officials and numerous advocacy groups. These bills would have abolished DMHMR.

In response to a legislative inquiry regarding the transfer of responsibilities and functions assigned by statute from DMHMR to Health by an executive order in the absence of legislation, the Attorney General and Reporter issued Opinion No. 98-041 on February 9, 1998. This opinion stated "The governor does not have the authority to abolish a statutorily created department."

In early 1998, management of both departments developed a five-year interdepartmental agreement, which effectively combined and/or co-located the staff of the two departments. The contract was signed by both commissioners, and approved by the Commissioner of the Department of Finance and Administration. In April 1998, the agreement was submitted to the Comptroller of the Treasury for approval because it was a multi-year agreement. The Comptroller's Office asked the Attorney General and Reporter for an opinion on whether it would be legal for the departments to enter into this interdepartmental agreement. The Attorney General has answered "The agreement's proposed "co-location" of staff is not expressly authorized by any statutes we have identified and appears inconsistent with certain statutory requirements. The configuration of attorneys would violate Tenn. Code Ann. 8-6-301(a), which this Office interpreted in Op. Tenn. Atty. Gen. 97-001 (January 6, 1997)." Under the circumstances, the Comptroller has not approved the agreement.

However, as early as January 1997, in anticipation of the merger, management of the departments coordinated activities and consolidated staff in several areas.

Staff was consolidated into seven major functional areas: (1) budget and finance—February 1998, (2) information systems—December 1997, (3) internal audit—March 1997, (4) legal services—January 1997, (5) licensure and regulations—November 1997, (6) personnel—November 1997, and (7) policy, planning, and assurance—March 1998. Staff for five of the functional areas noted above have been physically located together (co-located), and staff for the remaining two areas have been combined. The offices of the Commissioners of Health and DMHMR, however, are located in separate buildings.

Six of the seven functional areas (all except information systems) have a single director who supervises the consolidated staff. The directors of budget and finance, internal audit, licensure and regulations, and personnel, are Health employees and report to both the Commissioner of Health and the Commissioner of DMHMR, depending on which department is affected by a particular issue. The director of the combined policy, planning, and assurance staff is a DMHMR employee but reports to the State Health Officer. The general counsels of each department report directly to their respective commissioners. However, Health's general counsel appears to play a facilitating role between the legal staff of the two departments, assisting in interagency communications on legal issues that affect both departments.

Health's Director of Internal Audit uses combined staff not only to perform audit work for his department, but also, under annual contracts, to perform audit work for DMHMR in the mental health area, and the Department of Finance and Administration in the mental retardation area. If the lines of authority and responsibility are not clearly established for each department's internal audit function, the internal audit function may not provide unbiased audits and recommendations to management.

Although the General Assembly did not enact the proposed legislation to merge these two departments, the merger has effectively occurred because of the consolidation of departmental functions and staff.

A department's organizational structure provides the framework within which its activities for achieving department-wide objectives are planned, executed, controlled, and monitored. Without a clear delineation of the departments' internal control systems and organizational structure, management cannot be assured of effective and efficient operations, reliability of financial reporting, and compliance with applicable laws and regulations.

Recommendation

The departmental functions of Health and Mental Health and Mental Retardation should not be merged without legislative authority. The organizational structure and internal control systems for each department should be conducive to the needs of each department in terms of their mission. The departments should establish and maintain a relevant organizational structure which includes consideration of key lines of authority and responsibility and appropriate lines of reporting.

Management's Comment

We do not concur.

The Department of Health agrees that the Department of Health and the Department of Mental Health and Mental Retardation must have legislative authority in order to merge functions. The Departments have not effected such a merger.

The functional areas of Budget and Finance, Information Systems, Legal Services, Licensure and Regulations, and Personnel for both departments are referenced in one Interdepartmental Agreement. While these functional areas from both departments have been physically located next to each other, the staff of each of the departments have not merged. There are clear reporting lines from the staff to the Commissioner of the Department in which the individual was hired. There is a director level person in each department for each functional area who reports to the Commissioner in that same department, e.g. there is a Director of Budget and Finance in the Department of Health who reports to the Commissioner of Health and there is a Director of Budget and Finance in the Department of DMHMR who reports to the Commissioner of DMHMR. Staff of the Department of Health conduct the work of the Department of Health and staff of the Department of Mental Health and Mental Retardation conduct the work of the Department of Mental Health and Mental Retardation. Performance Evaluations of staff are conducted by the supervisory staff in the Department in which the individual was hired. The terms of the Interdepartmental Agreement which relate to supervision across departmental lines were never implemented in these functional areas. While there was some confusion early on, staff is not currently supervising across departmental lines. However, the directors of the functional areas in both departments, and in some instances the staff of the functional areas in both departments, meet with each other to discuss common issues and problem solve, a practice common in State government as a whole.

The remaining functional area covered by this Interdepartmental Agreement is Policy, Planning and Assurance. The Department agrees that the director is a DMHMR employee who reported to the State Health Officer, that the staff supervised are both Health and DMHMR staff and that certain DMHMR staff were conducting work for the Department of Health. As a result of this review, appropriate positions have been requested for the Department of Health in the expansion budget and the Department of Health is identifying positions that can be reclassified to accommodate Department of Health staff needs. DMHMR staff will report to a DMHMR supervisor.

As a result, the Interdepartmental Agreement which has never been fully implemented will be terminated.

Internal Audit is covered by a separate Interdepartmental Agreement. All employees reporting to the Director of Internal Audit are Department of Health employees. The Department of Mental Health and Mental Retardation is contracting with the Department of Health to provide

audit services. Appropriate payment will be made by DMHMR to the Department of Health for these services.

Rebuttal

The March 1999 Performance Audit of the Department of Health released by the Division of State Audit describes the extent of actual consolidation between these departments as recent as the reorganization in February 1999.

TENNCARE

Our audit of this major federal program focused on the compliance requirements for the Medical Assistance Program in the "Compliance Supplement" to Office of Management and Budget's Circular A-133, “Audits of States, Local Governments, and Non-Profit Organizations,” as well as several other areas. As such, the audit consisted of the following individual sections

- Activities Allowed or Unallowed and Allowable Costs / Cost Principles
- Cash Management
- Eligibility
- Matching, Level of Effort, Earmarking
- Period of Availability of Federal Funds
- Procurement and Suspension and Debarment
- Program Income
- Reporting
- Subrecipient Monitoring
- Special Tests and Provisions
- Schedule of Expenditures of Federal Awards
- TennCare Administration
- Financial (Accounts Receivable, Accrued Liabilities, Other Liabilities)
- TennCare Management Information System General Controls
- Internal Audit

The principal, specific audit objectives were

- to document, test, and assess the components of internal control (control environment; risk assessment; control activities; information and communication; and monitoring);

- to determine if grant funds were expended only for allowable activities;

- to determine if direct charges to Federal awards were for allowable costs and indirect cost rates were the result of applying the approved rate(s) to the proper base amount(s);

- to determine whether procedures were followed to minimize the time elapsing between the transfer of funds from the United States Treasury and their disbursement;

- to determine if management complied with the terms and conditions of the Cash Management Improvement Act Agreement between the State and the Secretary of the Treasury, United States Department of the Treasury (State-Treasury Agreement);

- to ensure that the Federal share of program refunds was remitted promptly to the grantor;

- to verify that only those eligible, according to state and federal guidelines, were enrolled in the program;

- to provide reasonable assurance that matching requirements were met using only allowable funds or costs which were properly calculated and valued;

- to provide reasonable assurance that Federal funds were used only during the authorized period of availability;

- to provide reasonable assurance that procurement of goods and services was made in compliance with the provisions of applicable regulations and guidelines, and that no subaward, contract, or agreement for purchase of goods or services was made with any debarred or suspended party;

- to provide reasonable assurance that program income was correctly earned, recorded, and used in accordance with the program requirements;
- to ensure that reports of Federal awards that are submitted to the Federal awarding agency include all activity of the reporting period, are supported by underlying accounting or performance records, and are submitted in accordance with program requirements;

- to determine whether subrecipients were properly monitored to ensure compliance with Federal award requirements;

- to verify that the procedures for investigations of suspected fraud were in accordance with program requirements;
- to ensure that audits of providers participating in the program were performed in accordance with program requirements;

- to determine whether TennCare had performed the required automated data processing (ADP) risk analysis and system security review;

- to determine if providers of medical services are licensed to participate in the TennCare/Medicaid program in accordance with federal, state, and local laws and regulations, and have made the required disclosures to the state;

- to ensure that TennCare maintains accurate licensure information on participating providers;

- to determine if the facilities which serve Medicaid recipients met the prescribed health and safety standards and the inspection surveys were performed in a timely manner;

- to ensure that management complied with the terms and conditions of the TennCare waiver agreement with the Health Care Financing Administration (HCFA);

- to verify that the Schedule of Expenditures of Federal Awards was properly prepared and adequately supported;

- to obtain an understanding of and document the main goals and objectives, and the organizational and functional structure, of the TennCare (Medicaid) program;

- to determine whether the accounts receivable were properly maintained and recorded;

- to determine if the accounts receivable recorded in STARS were adequately supported;

- to ensure that the assistance grant accrued liabilities were adequately supported and properly recorded in STARS;

- to determine if system security and system change procedures were adequate;

- to determine if internal audit conducted audits, reviews, or investigations of the TennCare program.

The procedures performed to achieve the objectives are described below.

Internal Control

Auditors administered planning and internal control questionnaires; reviewed written policies, procedures, and grant requirements; prepared internal control memos; performed walk-throughs and other detailed tests of controls; and assessed risk.

Activities Allowed or Unallowed and Allowable Costs/Cost Principles

Nonstatistical samples of capitation payments to the managed care organizations (MCOs) and behavioral health organizations (BHOs) were tested to determine that the correct rate had been paid. Auditors tested nonstatistical samples of Medicaid claims (e.g., nursing home claims) to determine if the claims were paid correctly. Computer-assisted audit techniques (CAATS) were used to search the payment data files for payments made on behalf of deceased enrollees and incarcerated youth.

Supporting documentation for all significant expenditure items was obtained and examined. Auditors performed reconciliations to determine that the amounts recorded in STARS agreed with the amount of checks issued and selected federal reports. Supplemental funding pool payments were tested for compliance with the methodologies approved by the grantor.

Cash Management

Auditors tested nonstatistical samples of Federal cash drawdown transactions for compliance with the State-Treasury cash management agreement. A nonstatistical sample of program refunds was tested to determine if the federal share of the refunds was properly and timely returned to the grantor.

Eligibility

Using information in the Automated Client Certification Eligibility Network (ACCENT) system and the TennCare Management Information System (TCMIS), auditors tested a nonstatistical sample of Medicaid-eligible TennCare enrollees to determine if the individuals were, in fact, eligible for TennCare and if eligibility redeterminations had been performed as required. Nonstatistical sampling was also used to determine whether children in state custody, on whose behalf TennCare made payments to the Department of Children's Services (Children's Services), were eligible for TennCare.

A statistical sample of "uninsured and uninsurable" enrollees was tested to determine if the individuals met federal and state eligibility requirements and if TennCare had updated or reverified their eligibility information within the past year. A nonstatistical sample of individuals not eligible for TennCare but for whom the state pays the BHOs was tested to determine that they were not enrolled in TennCare and no payments had been made to the MCOs on their behalf. In addition, auditors used CAATs to search the payment data files for invalid social security numbers.

Matching, Level of Effort, Earmarking

Period of Availability of Federal Funds
Procurement and Suspension and Debarment
Program Income

To provide reasonable assurance that matching requirements were met using only allowable funds or costs which were properly calculated and valued, auditors interviewed the key personnel responsible for this function in the Division of Budget and Finance and examined selected reports. Auditors obtained and reviewed documentation from the grantor concerning the approved period of availability of federal funds and compared it to total federal program expenditures. Key employees were interviewed about the procurement of goods and services and program income.

Reporting

Auditors inquired about the procedures for preparing, reviewing, and ensuring the timely submission of reports. Reported amounts were recalculated and supporting documentation for the information presented was reviewed.

Subrecipient Monitoring

Auditors inquired about the procedures for monitoring subrecipients. We reviewed the documentation concerning the payments to the state's four medical schools for "graduate medical education" and tested the payments to ensure that the amounts paid were correct. A nonstatistical sample of reimbursement claims from Children's Services was tested. Supporting documentation for the claims was examined to determine if the charges were valid, allowable, and properly calculated. The related case files at the community service agencies (CSAs) were reviewed for evidence that the children in the sample had actually received the services for which TennCare had reimbursed Children's Services.

Special Tests and Provisions

Case files maintained by the program integrity unit were reviewed to determine if the procedures for investigations of suspected fraud were in accordance with program requirements. Auditors also interviewed staff in the Medicaid Fraud Control Unit at the Tennessee Bureau of Investigations. The individuals responsible for auditing the providers participating in the program were interviewed and related documentation was reviewed. The requirement for performing ADP risk analysis and system security reviews was discussed with the appropriate personnel.

The files for a nonstatistical sample of Medicaid providers were examined to determine that the providers were licensed in accordance with program requirements. Auditors also performed tests to determine if facilities participating in the program had been inspected timely. The terms and conditions of the TennCare waiver were discussed with various key employees and corroborating evidence was reviewed to determine if management had complied with the provisions of the waiver, as required.

Schedule of Expenditures of Federal Awards

Auditors reviewed and verified the grant identification information on the Schedule of Expenditures of Federal Awards (SEFA) prepared by staff in the Division of Budget and Finance. Total reported expenditure amounts were traced to supporting documentation and the reconciliations used to prepare the SEFA were tested for accuracy.

TennCare Administration

The mission statements for the department and TennCare program were reviewed. Organization charts and descriptions of the functions and responsibilities of each division within the Bureau of TennCare were obtained and reviewed. Auditors documented the TennCare-related functions and responsibilities of other departments, the CSAs, and the local health departments. The nature of the work performed by key external entities that audit, monitor, or review various aspects of the TennCare program also was documented.

Financial

The policies and procedures for, as well as the various types of, accounts receivable were discussed with the personnel responsible for this function in the Division of Budget and Finance. In addition, reports and other documentation were reviewed to determine the receivable amounts. The receivables recorded in STARS were traced to supporting documentation. Auditors compared the current-year accrued liabilities to prior year amounts and obtained explanations for significant variances. Significant individual amounts were tested for reasonableness (many of the amounts were estimates) and adequacy of support.

TennCare Management Information System General Controls

We documented the functions and responsibilities of the Division of Information Services, the information system contractor, and the Office for Information Resources in the Department of Finance and Administration with regard to the TCMIS. Auditors documented system security and system change and work request (SCR/WR) procedures, reviewed related reports and manuals, and performed walk-throughs.

Detailed testwork was performed to determine the TCMIS transaction screens to which all TennCare users had access, and if the system access identification numbers of terminated employees were removed from the system timely. Also, a nonstatistical sample of SCRs and WRs was tested to determine whether the controls over system changes were in place as described by management.

Internal Audit

Auditors contacted personnel in the Office of Audit and Investigations (internal audit) to determine if any audits, reviews, or investigations of, or related to, the TennCare program had been conducted during the fiscal year. Reports and other documentation of the results of the work performed by internal audit were reviewed.

The findings that resulted from our audit of the TennCare program follow. In addition to the findings, other minor weaknesses came to our attention which have been reported to management in a separate letter.

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2. TennCare eligibility verification procedures are not adequate

Finding

The three prior audits of the Bureau of TennCare noted that in many cases, the eligibility of TennCare participants who are classified as uninsured or uninsurable had not been verified. Management concurred with the prior finding, stating that face-to-face enrollment and reverification projects would confirm eligibility information onsite. However, based on this audit, verification procedures did not adequately ensure all TennCare participants were eligible. Additionally, TennCare does not have an effective method to monitor the eligibility of TennCare/Medicaid recipients who are eligible because they receive Supplemental Security Income (SSI). See finding 17 for more information on the ineffective monitoring of SSI eligibility.

TennCare's reverification project began in June 1998, the last month in the fiscal year, and established face-to-face interviews for eligibility updates. This project was intended to reverify the eligibility of one-twelfth (1/12) of the entire uninsured and uninsurable population each month. TennCare also relied heavily on updates to the TennCare Management Information System (TCMIS) for reverifying eligibility through data matches and information received from various sources. These verification procedures, however, did not adequately ensure all TennCare participants were eligible.

Testwork revealed that 42 of 245 (17%) uninsured and uninsurable participants had not had their eligibility information updated in the last year. For 21 of the 42 found without updates, eligibility information had not been verified since initial enrollment in 1994.

Furthermore, using computer-assisted audit techniques to search the TennCare Management Information System (TCMIS), auditors found several TennCare participants had "pseudo social security numbers," e.g., numbers that began with 8 or had all zeros in one field. According to TennCare personnel, some applicants who do not have their social security cards and/or newborn children who have not yet been issued social security numbers are assigned these

"pseudo" numbers. Management concurred with the prior finding stating that the reverification project described above would help ensure that valid numbers are obtained for enrollees when available.

Testwork revealed that 84 of 140 (60%) individuals found with "pseudo" social security numbers had not had a correct social security number entered on TCMIS, although the enrollment dates exceeded almost a year. Some of the TennCare participants found had been enrolled as early as 1983. Also, while it is not always possible to obtain social security information for newborns (0-3 months), auditors noted that several individuals with pseudo social security numbers were over a year old. As noted in the prior audit, management stated that TennCare strives to provide needed care to children as soon as possible and that the reverification project would help ensure that valid numbers can be obtained after enrollment.

According to the *Code of Federal Regulations*, Title 42, Section 435.910, the state agency must require, as a condition of eligibility, that those requesting services (including children) provide social security numbers. Additionally, Section 3(g) of the Code states that the agency "must verify the social security number of each applicant and recipient with the Social Security Administration, as prescribed by the Commissioner, to insure that each social security number furnished was issued to that individual, and to determine whether any others were issued."

Adequate verification procedures are needed to ensure that only those eligible are enrolled in TennCare. According to Office of Management and Budget Circular A-133, payments are only allowed for individuals who are eligible for the TennCare/Medicaid program. The average amount paid per month to a managed care organization and to a behavioral health organization is $104 and $22, respectively. In fiscal year 1998, the Bureau paid $1,744,414,397 to MCOs and $325,590,444 to BHOs for TennCare enrollees.

Annual reverification is also necessary to obtain current, accurate information about family size, income, Tennessee residency, and access to other insurance. This information is also needed to determine whether participants previously considered eligible have become ineligible because of changes in their family or personal circumstances. Also, this information is used to determine the correct premium and deductible amounts paid by participants. TennCare's inadequate verification procedures will be reported as a repeated material internal control weakness in the 1998 Tennessee Single Audit Report.

Recommendation

The Commissioner and the Assistant Commissioner for TennCare should ensure that verification procedures are adequate, timely, and fully implemented. To evaluate the effectiveness of the procedures, reports detailing verification results should be produced regularly and reviewed for content and accuracy by the Director of Operations. Appropriate steps should be taken in response to the results of those reports. If reports are not made timely, the reason for the delay should be determined and corrected.

Management's Comment

We concur that a formal face-to-face reverification process for the uninsured/uninsurable was not in place during the audit review period. As stated by TennCare to previous audit findings, even though a formal reverification process was not in place during the audit period, attempts were made to update enrollee information based on data obtained through various sources.

In April 1997, the TennCare Section of Information Services and the Facilities Manager (EDS) designed and implemented a new application processing subsystem. In conjunction with the new system, an on-line edit was created that would flag enrollees with duplicate applications. The edit reported any new application for an enrollee that had existing TennCare eligibility under another uninsured/uninsurable application. This edit condition created a reporting mechanism that allowed TennCare to identify applications for enrollees with existing eligibility after the records had updated the TCMIS database. A process was implemented to compare the information reported on the new application against the information provided on the older application. Since the new application contains the more current information, the older case is closed. This review includes comparison of family members, income and other pertinent information. While this process depends on the submission of a new application and has not occurred on all cases, we consider updated information on the uninsured/uninsurable cases meeting this condition to be part of reverifying their eligibility.

TennCare officially implemented a face-to-face Reverification System in June 1998. The design, development, testing and implementation occurred during this audit review period. TennCare initiated various reverification projects during the past three years. It is important to note that the new application processing system implemented in April 1997 became the foundation of the current production Reverification System. The enhancements of the current application subsystem eliminated many of the obstacles that prevented previous reverification implementations.

Information Services conducted numerous meetings with Health Department and TennCare Policy staff on the overall design and development of the Reverification project. The meetings were critical to evaluate staffing needs and system load/processing capabilities for 95 county Health Departments who would be responsible for conducting reverification interviews.

Reverification application data entry screens were constructed with on-line connectivity for all county Health Departments to the TennCare Management Information System (TCMIS). The screens would allow the Health Departments to enter new case information and edit the data for approval /denial results. Edit logic was implemented that provided Health Department staff with a screen that detailed whether the enrollee would remain eligible for TennCare. The screen would provide the detailed reason why an enrollee would no longer be eligible. Training regions were established within the OIR CICS on-line system for use by Health Department staff for Reverification training. In addition, a training packet that detailed reverification information was prepared to assist in the training process.

The Health Departments included information in their training that addressed validation of Social Security Numbers and obtaining a valid number for enrollees with pseudo numbers. As stated in this audit finding, pseudo Social Security number assignments will continue to occur for newborns because TennCare does not want to delay a child's access to health care because they haven't received an official Social Security number.

Notices are generated to cases that have been reverified. Each notice details family members approved for continued eligibility. Notices are also generated to enrollees losing TennCare eligibility, which informs them of their appeal rights.

The Bureau of TennCare worked with key Health Department staff in the determination on the number of cases to select for reverification each month. Staffing and other Health Department required activities were considered in the number of monthly cases selected for reverification.

The initial uninsured/uninsurable population targeted for Reverification included all cases added 94 through 96. The following describes the status of the project through June 1, 1999. These numbers represent approximately 80% of the original projected number of cases for this time period. These numbers have not been reviewed by the auditors.

- 81,871 Reverification Initial Selection notices mailed (Cases)
- 41,495 Reverification Cases completed by Health Departments
- 37,643 Reverification Cases Approved for continuing eligibility
- 3,021 Enrollees terminated through Reverification process
- 5,967 Cases have members who have been terminated for undeliverable mail or no response to initial Reverification notice

The Reverification system produces numerous outputs that are used to monitor reverification activities. These reports are shared with key TennCare staff and other departments who are involved in Reverification monitoring.

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3. TennCare has not monitored TennCare-related activities at the Department of Children's Services

Finding

As noted in the previous audit and despite management's concurrence with the finding, TennCare has not monitored the Department of Children's Services (Children's Services) to ensure the accuracy and allowability of billings from that department. During the year ended June 30, 1998, TennCare paid approximately $101 million in fee-for-service reimbursement claims to

Children's Services. TennCare's failure to ensure Children's Services complied with all federal laws, regulations, and guidelines will be reported as a material internal control weakness in the 1998 Tennessee Single Audit report for the second year.

In accordance with its agreement with the bureau, Children's Services contracts separately with various practitioners and entities ("service providers") to provide health care benefits not provided by the managed care organizations (MCOs) and the behavioral health organizations (BHOs) under contract with TennCare. Children's Services pays these providers and bills TennCare for reimbursement.

TennCare has relied on Children's Services to ensure the following:

- Only services allowable under the grant are billed.
- The amounts billed are correct and allowable.
- The expenditures are valid and properly supported.
- Only eligible, licensed, or certified providers are providing the services.

Although TennCare relies on Children's Services to ensure compliance, the bureau does not monitor Children's Services.

This reliance includes not establishing predetermined, preapproved payment rates in the TennCare Management Information System (TCMIS), TennCare's claims processing and payment system, for all of the claims billed by Children's Services. When no rate is established in TCMIS, the system is programmed to pay any amount billed by Children's Services, without limit. TennCare has also relied on Children's Services to determine the treatment rates paid to the service providers for children in the state's custody. Children's Services pays the service providers for all services (treatment, room and board, and education) directly, then is permitted to bill TennCare only for the treatment portion. Based on testwork performed and numerous discussions with Children's Services management, management could not provide information as to how the treatment portion was determined. Without a methodology to determine the true treatment costs incurred by the service providers, Children's Services may be over- or underbilling TennCare for costs associated with medically necessary treatment. Because actual treatment costs could not be determined, auditors could not determine the amounts of possible overbillings to the federal government.

Testwork on Children's Services claims also revealed the following:

- No supporting documentation (e.g., no case files and related details) for 4 of 60 claims tested. The amount questioned will be $1,616.50.
- Children's Services billed TennCare for days when a child was on runaway status and no treatment costs were incurred by the service provider. The amount questioned is $1,364.94.

- Children's Services is paying service providers directly for children in custody who are classified as Seriously Emotionally Disturbed (SED). TennCare has also paid the enhanced BHO capitation rate for these children. The amount questioned will be $2,555.28.

Similarly, Children's Services claims are not reviewed or tested by TennCare's internal auditors, other bureau personnel, or the Department of Finance and Administration's Division of Research and Support. Although this problem was identified in the prior year's report, the TennCare bureau, again, has not monitored Children's Services' practices and ultimately was unaware that Children's Services billed for the health care costs of incarcerated children who were not eligible for Medicaid (TennCare). See finding 10 for more details.

As noted in the previous audit, the TennCare Bureau had only to review the audit reports on the Department of Children's Services to note serious compliance and internal control problems. For the past four fiscal years, the audit reports on Children's Services have contained numerous findings, many of them repeated from year to year. Although the testwork at Children's Services did not always include TennCare transactions, the general lack of internal control presents an unacceptable level of risk for TennCare transactions. TennCare management concurred that the level of risk for TennCare transactions was unacceptable. The deficiencies listed below highlight this risk:

- Duplicate payments and overpayments were made to providers.
- Invoices did not contain certification that services had been provided.
- Invoices were not properly approved for payment.
- Documentation was not sufficient to verify the allowability of payments.
- Controls are insufficient to prevent unauthorized changes to the system used to process payments.
- Reimbursement requests for federal dollars are not made in a timely manner.

Recommendation

The Commissioner should determine why Bureau staff failed to ensure that the Department of Children's Services properly administered its responsibilities under the TennCare program. All necessary steps should be taken to ensure that Bureau staff monitor Children's Services regularly for fiscal and programmatic compliance. The Commissioner and Assistant Commissioner should work with Children's Services to establish treatment costs for children in state custody.

Management's Comment

We concur. The Department of Health has entered into an agreement with the Department of Finance and Administration to monitor several aspects of the Department of Children's Services including internal controls. We have also met with the Department of Children's Services to review deficiencies noted by the fiscal year 1997 Comptroller audit of DCS, and the agreement with the Department of Finance and Administration will be used to follow-up on the corrective actions proposed by DCS. A task force headed by the Department's Director of Budget and Finance is working to establish a new rate setting methodology for children in state custody.

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4. TennCare Management Information System lacks the necessary flexibility and internal controls

Finding

Management of the Bureau of TennCare has failed to address critical information system internal control issues. In addition, the TennCare Management Information System (TCMIS) lacks the flexibility it needs to ensure that the Department of Health and ultimately the State of Tennessee can continue to run the state's $3.6 billion federal/state health care reform program effectively and efficiently.

Because of the system's complexity, frequent modifications of the system, and because this system was developed in the 1970s for processing Medicaid claims, TennCare staff and Electronic Data Services (EDS) (the contractor hired to operate and maintain the TCMIS) primarily focus on the critical demands of processing payments to the managed care organizations, behavioral health organizations and the state's nursing homes rather than developing and enhancing internal controls of the system.

According to Bureau personnel, the Director of Information Services alone prioritizes any system change requests, work requests, or any special requests for system information. If such a request does not involve the payment function to the external contractors, it is unlikely to be viewed as a priority according to bureau staff. Furthermore, the Director of Information Services does not penalize EDS when the contractor fails to perform under their contract.

As evidenced by the number of new and repeat findings, management of the department has not made internal control a priority. The TennCare bureau

- has not strengthened system security controls related to access (finding 5), which resulted in a material weakness in internal control;
- currently utilizes two systems to prepare the required federal reports (finding 6);

- has not made payments to certain providers in accordance with the rules (finding 7);
- has not strengthened system controls for Medicare professional cross-over claims (finding 8);
- made capitation payments for individuals who were not eligible for TennCare (findings 9 and 10);
- failed to promptly update the system to process $59 million of mental health waiver claims and reimburse the Department of Mental Health and Mental Retardation timely which resulted in lost interest income on the $59 million of state funds used to pay that department's providers (finding 11);
- did not provide information necessary to conduct audits of TennCare timely (finding 12).

In its three-year information system plan dated July 1, 1998, TennCare submitted a proposal to study the replacement of TCMIS. According to Bureau personnel some progress has been made; however, due to concern about year 2000 issues, progress has been slow.

Recommendation

The Commissioner and the Assistant Commissioner for TennCare should consider the seriousness of the findings contained in this report and the nature and broad extent of repeat findings and make a commitment to regain control of the program. The Assistant Commissioner should assist the Director of Information Services in setting priorities for system changes and updates. Internal control responsibilities should be taken more seriously and given a higher priority. Penalties should be enforced as allowed by the contract when EDS fails to perform as required. In addition, the department should pursue the acquisition of a system designed for the managed care environment. The Commissioner and the internal audit unit should frequently monitor the activities of the responsible individuals correcting the problems and determine whether progress is being made. The Commissioner should take appropriate action if the problems are not corrected in accordance with the plans of action.

Management's Comment

We concur in part with the finding that the current TennCare Management Information System (TCMIS) should be analyzed to ensure that the TCMIS will continue to support the overall mission and goal of the TennCare program.

Prior to the inception of the TennCare program, the Information Systems in place were stable. The implementation of the TennCare program resulted in substantial new business and programming requirements. Furthermore, changes in business requirements and their relative priorities continue to drive new requirements and priorities for information systems support.

These stages can be expected to continue until the program becomes more mature and predictable.

The overall information systems design does currently supply functional capability to address many of the critical TennCare business needs. However, the information systems in several areas of the TCMIS does not support the requirements adequately.

The current TCMIS uses a single-tier technical architecture consisting of the host computer (IBM compatible legacy mainframe), MVS/ESA as its operating system, TSO/CICS/-Cobol II as the development environment and VSAM as the vital structure. The TCMIS contains well over 200 gigabytes of data and is accessed by numerous TennCare users. This technical architecture is adequate in areas such as the maintenance of a large enrollee eligibility database and the processing of capitation payments to MCOs and BHOs. However, certain areas of the TCMIS do not adequately support the business environment. Data is maintained on separate large files and critical information within each file is not consolidated within a single database. Access to and quick retrieval of information contained within the TCMIS is cumbersome. Ad hoc reports are slow to execute because they run against large databases which were originally designed for data entry and transaction processing and not originally designed for data access and retrieval.

TennCare was able to provide significant improvement in the area of data analysis through the acquisition and implementation of the decision support system which utilizes the PANDORA software in which data storage is highly structured and uses an operational database geared for data access and retrieval. This decision support system is utilized to analyze encounter data reported by the MCOs and BHOs to TennCare.

Because of the integrated nature of a managed care information system, there is little opportunity to replace one module of the TCMIS with the "Best in Class Module from any commercially available managed care information systems." We believe that opportunities exist to replace and/or layer additional subsystems on top of the TCMIS base in order to supply flex-ible functionality more rapidly. The Department currently has a project proposal to study replacing or adding layers to the existing TCMIS with newer technology. The Commissioner has been meeting with key TennCare staff within the Department and the Bureau of TennCare and with key staff from the Department of Finance and Administration to review the overall business goal and objectives of this proposal.

We do not concur with the finding that the Director of Information Services alone prioritizes any system change requests. The priorities for the TennCare program are set by the Assistant Commissioner. These priorities are influenced by: the program needs, needs of our Federal partner, input from other State officials, and input from provider and consumer groups. It is the Director of Informations Services responsibility to prioritize the information system work in order to address the program priorities set by the Assistant Commissioner. A formal process for managing the deployment of information systems resources to support program priorities exists. Ensuring that program priorities are being addressed is a major goal of the TennCare Information Services Director and his staff. Their daily activities include formal meetings with TennCare

Facilities Manager Contractor, EDS. Every effort is taken to formally identify resources available for systems development and system change requests and to produce reports to meet information requests. With the immense demands placed on the old system, pressures can increase for immediate needs. The TennCare Information Services Director is dedicated and committed to rapid response in spite of system limitations.

The facility's manager contractor has experienced difficulties in retaining staff with TCMIS experience. This impacts TennCare's ability to respond to request for information requiring ad hoc reports. However, every effort continues to occur in ensuring that priority requests are responded to timely and that all requests are responded to in a responsible manner. The TennCare Information Services Director is working with current EDS TennCare account management to identify and implement options for responding to the increasing demands on the system. It should be noted that the current year 2000 project has had and is having an impact on the availability of resources. The Information Services Director will work with the Assistant Commissioner when applicable to enforce penalties when the contractor fails to perform adequately. The contractor recently was placed on liquidated damages penalty for failure to complete specified contract requirements by the designated due date.

Internal control will be focused on as a high priority. A plan of action will be developed to address weaknesses. The Internal Audit unit will monitor the progress of the individuals implementing the plan of action to assure appropriate action in accordance with the plan.

Auditor's Comment

Based on interviews with bureau staff, the auditors' understanding was that the Director of Information Services prioritizes the deployment of information resources. The process of deployment was not fully described until "Management's Comments" were received on June 7, 1999.

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5. Controls over access to the TennCare Management Information System are weak and inadequately documented

Finding

One of the most important responsibilities, if not the most important, for the official in charge of an information system is security. The Director of Information Services and the Security Administrator have held these positions at TennCare for five and four years respectively. The Director of Information Services is responsible for but has not implemented adequate TennCare Management Information System (TCMIS) access controls. As a result, numerous deficiencies in controls were noted during system security testwork. In addition, existing controls

are not adequately documented. These weaknesses will be reported as a material internal control weakness in the 1998 Tennessee Single Audit report.

The TCMIS contains extensive recipient, provider, and payment data files; processes a high volume of transactions; and generates numerous types of reports. Who has access, and the type of access permitted, is critical to the integrity and performance of the TennCare program. Good security controls provide that access to data and transaction screens be limited to a "need-to-know, need-to-do" basis. When system access is not properly controlled, there is a greater risk that individuals may make unauthorized changes to the TCMIS or inappropriately obtain confidential information, such as recipient social security and Medicaid identification numbers, income, and medical information.

Current and complete documentation is necessary to adequately administer and monitor user access and system security and to increase accountability to management and internal and/or external auditors. Audit testwork revealed the following discrepancies.

No Security Authorization Forms

Access to TCMIS is controlled by Resource Access Control Facility (RACF) software. The purpose of RACF is to prohibit unauthorized access to confidential information and system transactions. The TennCare Security Administrator in the Division of Information Services is responsible for implementing RACF, as well as other, system security procedures.

The Security Administrator assigns a "username" ("RACF User ID") and establishes at least one "user group" for all TennCare Bureau and TCMIS contractor users. User groups are a primary method by which RACF controls access. Each member of a user group can access a set of TCMIS transaction screens.

The Security Administrator assigns every user to the "default group." To determine which other user groups, if any, an individual should be placed into, the Security Administrator determines the type of access other employees in the new employee's work area have and assigns him or her the same type of access. Therefore, access may not be assigned based on true needs because there is no signed and approved security authorization form or documentation explaining the type and level (inquiry or update) of access required, except for programmers.

Failure to require signed security authorization forms with proper supervisory approval makes it more difficult to monitor user access. For example, it is not possible to compare the type and level of access needed and requested with the type and level of access given.

Unnecessary Access to TCMIS

User access testwork revealed that all users in the default group have access to at least 44 TCMIS transaction screens, some of which are not necessary for the performance of each user's job duties. Because of the lack of documentation, we were not able to determine the exact number of transaction screens available to the users in the default group or the nature and purpose of each transaction available. More generally, the Director of Information Services did not

provide a comprehensive list and detailed descriptions of all TCMIS transaction screens, i.e., the transactions available to users in the default group and transactions available to users assigned to additional groups, as well.

Transaction Screens Not Protected

As discussed earlier in this finding, typically users must have a RACF user ID to sign on to TCMIS and access TennCare transaction screens. The auditors discovered that many transaction screens, including but not limited to recipient inquiry, eligibility history inquiry, Medicare history inquiry, long-term history inquiry, and liability history inquiry could be accessed without a user ID. This could occur if a user pressed a particular function key during the sign on process. The function key enabled the user to bypass the sign-on process and go directly to the transaction command screen. At that point, the user could enter one of the transaction screen commands and obtain unauthorized access.

This condition apparently existed because security levels for many screens were set to minimal values to facilitate a quick switchover when the old Medicaid system was modified for TennCare purposes. This occurred five years ago, but apparently no correction of the security weakness had been considered. Based on discussion with management during fieldwork, auditors recommended TennCare management review security settings for all screens and set the appropriate security parameter tables and security keys as deemed necessary.

More Lack of Documentation

TennCare personnel did not provide the following basic and essential information:

- documentation describing the purpose and proper composition, by job function, of the various TennCare user groups;
- a complete list and descriptions of all "external" TCMIS users, and explanations why the access is needed (external users were defined as users who are not employees of TennCare or the TCMIS contractor);
- the access to individual transaction screens available to all TennCare, TCMIS contractor, and external TennCare users;
- an overall diagram of the TCMIS that shows all of the various subsystems and modules;
- a list and description of the TCMIS-related functions performed by the Office for Information Resources (OIR), Department of Finance and Administration; and
- a list of policy and procedure manuals concerning the use and control over the TCMIS (both user and technical manuals).

It is difficult to understand how the individuals responsible for this system could perform their duties without having this information readily available. When this type of fundamental information is not available and organized it calls into question how the system can be effectively managed at all.

Security Administration Not Centralized

Testwork also revealed that the Security Administrator for the Department of Health, who is separate from TennCare's Security Administrator, gives users access to TCMIS. The department's Security Administrator is not required to notify the TennCare Security Administrator when users are given access to TCMIS. Furthermore, if users' RACF user names expire, the TennCare Security Administrator can reinstate the access of users given by the department's Security Administrator, and vice versa. When access to TCMIS is decentralized it is more difficult to monitor and control.

The TennCare Security Administrator relies on security administrators in other departments when a user in another department wants access to TCMIS. Although other departments' security administrators contact the TennCare Security Administrator to obtain the access, no explanation of why access is needed is required before access is given.

Lack of Monitoring

According to TCMIS system security personnel, users' type and level of access is not reviewed periodically. In general, management relies on individual supervisors to contact the Security Administrator if changes are needed. The Security Administrator stated, however, that often he was not informed. Although one would expect that if more access were needed users would contact the Security Administrator promptly, however users may not be as concerned about reporting the need for less access, as a result of changes in job responsibilities.

TennCare Application Data Entry Weakness

A report issued by the department's Office of Audit and Investigations in April 1998 noted that because TCMIS is "routinely down" employees at the Lakeshore Mental Health Institute leave "the system 'open' with their password allowing other employees to access the system." In addition, the report stated that adequate controls did not exist to prevent employees who enter TennCare application information into TCMIS from also approving the applications on-line. Good segregation of duties dictates that the data entry function should be separate from the approval function so that the same person cannot enter and approve a transaction. The auditor contacted the Director of Information Services to determine whether the concerns raised by the internal auditors had been addressed; however, no information was provided.

Employee Termination Procedures

According to the Security Administrator, TennCare has no procedures to ensure that user access is promptly canceled when employees are terminated from the department or the TCMIS contractor. The Security Administrator stated that supervisors for the contractor sometimes call him with the names of persons hired to replace terminated employees; however, he believed that improvement in this area was needed.

New TCMIS Transactions

As noted above, the auditor asked for a listing, with detailed descriptions, of all TCMIS transaction screens. Related to this, the auditors asked the Security Administrator if there were

procedures in place to ensure that he was informed, on a timely basis, of new TCMIS transaction screens.

The Security Administrator stated that the TCMIS contractor sends a form to the Office for Information Resources (OIR) in the Department of Finance and Administration when a new transaction screen is ready to be placed into production. The Security Administrator, however, does not receive a copy of the form and typically is not informed about new transactions in a timely manner. In addition, the Security Administrator stated that at times he had to guess which users needed access to new transaction screens.

Recommendation

The Director of Information Services should set a tone for serious commitment to internal controls and recognize the obligation to protect confidential client information against unauthorized access. Specifically, the Director of Information Services should require employees to complete and sign request forms that document their specific system access needs. A supervisor should approve the request forms, and the Director should review the forms to determine if the requests appear appropriate. The same or a similar form should be obtained from all external users before access to TCMIS is provided. The forms should include the user's name, position, and division.

The Director should redefine user groups to strengthen access controls. The Director also should ensure that adequate system security records and documentation are maintained. Also, all transaction screens should be properly secured and all documentation should be provided to the auditors, as soon as possible, upon request.

Responsibility for TCMIS security should be centralized under the TennCare Security Administrator. The Director should ensure that system security monitoring procedures are developed, written, and implemented. A record of the procedures performed, and the results, should be maintained. The Director needs to make internal control a priority and should ensure the Security Administrator promptly addresses system security and concerns raised by the internal auditors.

Management should ensure that procedures are developed and implemented to promptly cancel access of terminated employees. Periodic tests should be performed to determine that terminated employees are promptly removed from the system. The Director should take the necessary measures to ensure that adequate information about new TCMIS transactions is provided to the Security Administrator. The Security Administrator should not guess, but be informed, in writing, who should be given access to new transactions and the type of access (inquiry or update) required. Finally, supervisors should notify upper management when security breaches occur.

Management's Comments

We concur that there should be internal security controls for the TennCare Management Information System (TCMIS). The TennCare Director of Information Services and his staff are committed to protecting confidential client information. While we agree that all procedures may not be documented, there are procedures in place to control unauthorized manipulation of files.

During the review period, a formal procedure manual did not exist. Since then, the TennCare Information Services Security Administrator has begun the task of documenting the procedures that are in place in addition to those that are being implemented.

We are currently reviewing all processes that are in place to ensure that there are sufficient security measures in place, as well as adding procedures/policies where they are lacking. A new security authorization form is being developed and should document each employee's specific system access needs. External users will also be required to use the security authorization form.

No Security Authorization Forms

The Security Administrator conducts ongoing reviews to determine if there are users who do not have a security agreement on file. The security agreement forms are sent to the appropriate personnel to have signed and returned for filing. The current procedures in place require that the signed Security Agreement form be received before any ID is activated. Users and their managers that are identified without the proper security agreements on file receive notification that their RACF ID's will be revoked until the proper paperwork has been submitted. When the new security authorization form is implemented, periodic reviews will be conducted to assure their completeness and ongoing accuracy.

Unnecessary Access to TCMIS

While the default group has numerous transactions for inquiry and users in these groups may not have a need to use all transactions, they do perform functions that may require some or all types of inquiry, which are critical to TennCare business functions. The Director/Manager of each respective section or department is responsible for informing the TennCare Security Administrator which transactions are needed to perform their functions. The new security authorization form will contain information about each user to document particular need for access to various components of the system. A review is being done to the user groups to verify that the types of transactions for all groups are as they should be. Changes will be made as necessary.

Transaction Screens not Protected

This has been resolved. During the review, the audit team brought to our attention that a user could access inquiry to the system by pressing the F3 key to bypass the sign on screen. This was corrected immediately by the Information Services Section so that if an attempt was made to enter a transaction after the sign on screen was bypassed, an error message was returned.

More Lack of Documentation

The TennCare Information Services Director and his staff will review the items listed and assure that the necessary documentation is placed in the TennCare Security Administrator manual.

Security Administrator Not Centralized

We agree that it is necessary for the Security Administrator to be centralized. It is equally necessary for the Administrator to have sufficient backup. The Security Administrator for the Department of Health has served that purpose. TennCare was under the Department of Health at the time of the audit. The Bureau will explore naming a Bureau employee for backup. All security requests will be submitted to the TennCare Security Administrator and external users will be required to document why access is needed before access will be given.

Lack of Monitoring

Procedures are now in place to review all RACF ID security periodically.

TennCare Application Data Entry Weakness

The TennCare Security Administrator can not control whether a user leaves his/her ID signed on. Measures are in place and have been in place that systematically logs a user out of the system after a designated period of inactivity as defined by the Department of Finance and Administration, Office of Information Resources. TennCare will ask the Internal Audit unit to review the current application processing function to assure appropriate segregation of duties.

Employee Termination Procedures

Procedures are in place to notify the TennCare Security Administrator when an employee terminates to revoke their ID. The TennCare Information Services Section is working with all TennCare Sections, departments, and users to ensure that the Security Administrator is notified timely when their employees are terminated. The Internal Audit unit will conduct periodic tests to assure that terminated employees are promptly removed from the system.

New TCMIS Transactions

As new TCMIS transactions are implemented, descriptions will be added to the TennCare Security Administrators procedure manual along with RACF Security designations submitted in writing with other information deemed necessary.

Auditor's Comment

Security Administration Not Centralized

We agree that the TennCare Security Administrator needs sufficient backup. During the audit period, however, the Security Administrator for the Department of Health acted in more than a "backup" capacity. Based on discussions with both the TennCare Security Administrator and Health's Security Administrator, Health's Security Administrator generally acted independently of the TennCare Security Administrator. Health's Security Administrator gave access to the TCMIS without consulting with or informing the TennCare Security Administrator.

In fact, the TennCare Security Administrator was not aware of some of the transaction screens to which the Health Security Administrator was giving users access. Also, as stated in the finding, Health's Security Administrator was not required to notify the TennCare Security Administrator when access to the TCMIS was given.

Employee Termination Procedures

It is not clear from "Management's Comment" whether management disagrees with this section of the finding or if the procedures mentioned were implemented subsequent to the audit. During audit fieldwork the Security Administrator stated that he usually learned that an employee was leaving (or had already left) by word of mouth or, as stated in the finding, when supervisors with the TCMIS contractor sometimes called to notify him of personnel changes.

Also, the comment does not explain the nature of the procedures being used, e.g., an employee termination form or checklist. We strongly recommend that the Commissioner and the Director of TennCare ensure that formal procedures are developed and implemented to insure that the system access of terminated employees is canceled immediately.

During the next audit, the auditors will follow up on the finding to determine the existence and effectiveness of the procedures described by management.

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6. TennCare's Medicaid Accounts Receivable Recoupment System is an impediment to the collection of cost settlements and accurate federal financial reporting

Finding

As noted in the prior audit, the Medicaid Accounts Receivable Recoupment System (Recoupment System) is adversely affecting collection of provider cost settlements and federal financial reporting. This system, a database created many years ago to track and age Medicaid program receivables (including provider cost settlement receivables), should not be relied on because it contains old, inaccurate information.

Although aware of the system's unreliability, TennCare still uses the system to determine the amount of overpayment adjustments (reductions in expenditures claimed because of over-payments) reported on quarterly federal expenditure reports to the Health Care Financing Administration (HCFA). However, management is concerned enough about the system's reliability to delay requests to Medicare to withhold provider payments until the cost settlement balances can be researched and confirmed using the provider account information in the TennCare Management Information System (TCMIS). (See finding 15 for more information about working with Medicare to collect provider cost settlements.) TennCare uses both systems because the TCMIS has not been modified to age receivables and does not provide the detail needed to easily track and analyze the receivable accounts.

When the provider balances on the Recoupment System were compared to those on TCMIS, the more reliable system, discrepancies were noted creating uncertainty about the exact amounts some providers owe TennCare for cost settlements. Because of the complexity of TCMIS and the many transactions it processes daily (e.g., new and voided claims, retroactive rate adjustments), management had been reluctant until recently to undertake the time-consuming task of reconciling provider balances on the two systems. Had the balances on the two systems been reconciled periodically over time, TennCare would not now be having such difficulty.

When management reconciles the two systems, action can then be taken to collect the amounts due the state. However, it was determined that the on-site TCMIS contractor, Electronic Data Systems, takes two to three months to apply provider payments to the respective accounts receivable account. This delay creates large timing gaps between the two systems and adds confusion as to the correct amount of the receivable. In some instances, money was refunded to the provider when the provider actually had a zero balance or still owed TennCare.

Management concurred with the prior finding and hired an accountant to reconcile the systems. In addition, management stated that they were pursuing obtaining aged accounts receivable data through the TCMIS. Because this would require programming modifications to TCMIS, personnel in the Division of Budget and Finance submitted a "system change request" form to the Director of Information Services on April 3, 1997. As of November 1998, however, the requested system changes had not been made.

Accurate financial information is essential to effectively manage the fiscal operations of TennCare. When financial information and the systems used to compile the information are unreliable, management cannot make sound financial decisions, take appropriate action, and ensure the accuracy of federal financial reporting. In addition, it is time-consuming and costly to maintain and reconcile two computer systems.

Recommendation

To eliminate unnecessary or duplicate work and improve program financial management, including collection of accounts receivable, the Fiscal Director and his staff should perform a comprehensive review and assessment of their accounts receivable systems and procedures. The review should include the related procedures of the TCMIS contractor. Based on the results of the review, the Fiscal Director should take the appropriate steps to implement all needed changes, including system changes.

In the meantime, the Fiscal Director should ensure the provider balances on the TennCare Management Information System and the Medicaid Accounts Receivable Recoupment System are reconciled at least quarterly. Management should focus first on the most significant balances.

The Director of Information Services should ensure that the TCMIS is modified promptly to accommodate the financial management and reporting needs of the Division of Budget and Finance.

Management's Comment

We concur. The Bureau Fiscal Director and his staff will perform a comprehensive review and assessment of the accounts receivable systems and procedures. Staff will continue to take steps to identify and reconcile balances between TCMIS and the Recoupment system. The Director of Information Services will work with the Director of Budget and Finance to modify or convert the existing Recoupment system to eliminate the need to reconcile between the two systems.

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7. As previously noted, since 1995 TennCare continues to not pay certain providers in accordance with the departmental rules

Finding

As noted in the prior two audits, covering the period July 1, 1995, through June 30, 1997, because TennCare has not complied with departmental rules, providers caring for enrollees who are both TennCare and Medicare recipients are sometimes overpaid. Management concurred with the prior findings and recommendations, and stated in fiscal year 1996 and again in fiscal year 1997, management would examine whether it is more appropriate to change the rules or their method of payment. However, no changes to the computer system or the rules have been made.

According to the Director of Fiscal Services, as of February 1999, TennCare is still researching the rules and has not determined whether it is more appropriate to change the rules or the computer system.

Medicare recipients are required to pay coinsurance and a deductible to the provider for services received. If the patient is also eligible for Medicaid, Medicare bills TennCare instead of the patient for the coinsurance and deductible. According to departmental rules, the total amount paid by all parties (Medicare, patient, and TennCare) cannot exceed the fee limitation set by TennCare. However, TennCare's computer system always pays the entire deductible billed for outpatient hospitalization services regardless of how much Medicare or the patient paid or any limitations set by the Medicaid fee schedule.

Recommendation

The Commissioner should determine why the staff has taken so long to research the rules and make a decision whether the method of payment or the rules should change. When a final decision is made, the Assistant Commissioner for TennCare should ensure that the Director of Information Services promptly makes the necessary changes to the TennCare Management Information System to bring the method of payment into compliance with departmental rules or have the rules amended.

Management's Comment

We concur. TennCare staff will be working with the Director of TennCare to bring payment methods into compliance with departmental rules. Additionally, the Bureau will examine its process for updating policies, procedures, and computer systems to reflect new developments and procedures for testing the claims pricing and payment subsystems.

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8. TCMIS processing of Medicare professional cross-over claims still needs improvement

Finding

As noted in the prior audit, covering the period July 1, 1996, through June 30, 1997, there are several control weaknesses in the processing of Medicare professional cross-over claims (claims paid partially by both Medicare and Medicaid). The TennCare Management Information System (TCMIS) used to process these claims has not been modified and updated as needed to ensure claims are paid in compliance with state and federal laws. The amount of expenditures for professional cross-over claims during fiscal year 1998 was $46,437,425.17. Management concurred with the prior finding and stated that policies, procedures, and computer systems would be reviewed in order to make necessary modifications. Also, management stated that the claims pricing and payment manual would be reviewed for any indicated revisions and would be updated to reflect changes in law and grant guidelines. However, TennCare management has failed to take these measures.

- Although professional cross-over claims have been Medicaid-eligible since the late 1980s, these claims are to be denied if the recipients have other insurance (third-party resources). However, TCMIS has not been updated to detect third-party resources on these cross-over claims. Testwork revealed that TCMIS failed to deny two cross-over claims even though the recipients had supplemental insurance information on the system. The questioned costs will be reported in the Tennessee Single Audit Report for 1998 because the error projects to approximately $55,260. The total number of claims paid improperly and the actual total dollar amount paid in error for fiscal year 1998 was not determined.

- Despite the complex nature of the claims processing, bureau staff does not routinely perform manual pricing tests to determine if the system is paying claims properly.
- TennCare's fee-for-service claims pricing manual has not been updated.

Recommendation

The Commissioner should determine why TCMIS has not been updated to detect third-party resources on cross-over claims, and why the Director of the Policy Division has not revised and updated the claims pricing and payment manual to reflect changes in law and grant guidelines. Management and staff should keep abreast of new and changing program requirements and should ensure the bureau's policies, procedures, and computer systems are updated timely to reflect new developments. Also, the Commissioner and the Assistant Commissioner for TennCare should determine why the claims pricing and payment subsystem of TCMIS has not been tested routinely and take immediate action to implement testing.

Management's Comment

We concur. As stated in our response to finding 7, the Bureau will examine its process for updating policies, procedures, and computer systems for changes necessary to reflect new developments. Procedures will be implemented to assure that routine pricing tests are done to assure that claims are paying properly.

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9. TennCare paid over $6 million in capitation payments on behalf of deceased enrollees

Finding

Because TennCare failed to identify approximately 14,000 deceased enrollees, TennCare paid over $6 million in capitation payments to the managed care organizations (MCOs) and behavioral health organizations (BHOs) on behalf of the deceased enrollees during the fiscal year ended June 30, 1998.

Using computer-assisted auditing techniques, we performed a data match comparing payment data from the Bureau of TennCare to death records from the Office of Vital Records (Vital Records). The results of the data match indicated that TennCare had improperly paid $5,431,878 to the MCOs and $827,185 to the BHOs.

Although management has procedures for identifying and disenrolling deceased recipients, including matching TennCare recipient files electronically with death record updates from Vital

Records monthly, the procedures were not entirely effective. The Division of Information Services is responsible for performing all TennCare recipient eligibility data matches. According to the Director of Information Services, it appeared that the problem was caused by one or more of following:

- Only the most recent death record information from Vital Records was used for the data matches. The information did not include comprehensive death record information, or corrections.
- The criteria used by TennCare to detect actual and possible ("suspect") matches was too restrictive. The program written by the auditor, which was less restrictive, detected more deceased enrollees.
- Suspect matches were not followed up adequately.

According to a manager in the Division of Information Services, a recipient is not removed from the program unless TennCare is certain that their information is correct (that the person has died). Despite this concern, however, TennCare does not send letters to recipients who are possible matches, based on the results of TennCare's data matching procedures.

Also, each month TennCare receives doctor visit and medical procedure information ("encounter data") from the MCOs and BHOs. Currently, this data is not being used to detect recipients

- who have not used their TennCare benefits for an extended period of time and, therefore, may have died, moved out of the state, or obtained other insurance, or
- who have been reported as deceased by their providers.

In a related matter, a report prepared by the internal auditors for the period October 1, 1997, through December 31, 1997, indicated that bureau staff were not using system-generated paid claims reports to ensure that Medicaid claims, such as nursing home claims, had not been paid improperly on behalf of deceased recipients.

Management stated that the payments to the MCOs probably can be recovered. It appears, however, that the payments to the BHOs cannot be recovered because their contracts state that they will receive a predetermined, total, annual amount. In addition, it is possible that the contract payments to the two BHOs were not allocated properly. Even if the improperly paid funds can be recovered, the costs to the state in the wasted actions of processing and paying the ineligible payments, and the costs of recovery cannot be recouped. Of the total expenditure, $3,458,205 of federal funds will be a questioned cost on the Schedule of Findings and Questioned Costs in the 1998 Tennessee Single Audit Report.

Recommendation

Under the direction of the Commissioner, TennCare management should determine which capitation payments made on behalf of deceased recipients legally can be recovered and take the necessary steps to recover all such payments made since the inception of TennCare. Management also should consider whether any action is necessary regarding the monthly allocation of funds between the BHOs.

The Commissioner should ensure that the Director of Information Services considers the methodology used in detecting such payments and that the necessary changes are made to prevent future improper payments. The Director of Information Services should ensure that bureau staff effectively use the appropriate paid claims reports to determine if Medicaid claims have been paid improperly on behalf of deceased recipients, and prompt corrective action should be taken if improper payments are detected. Also, management should consider using the encounter data to detect changes in recipient eligibility.

Management's Comment

We concur. During the audit, TennCare staff met with the audit staff to discuss and validate methods used for the data match against the Vital Records files. The audit team shared their reports from the data match with TennCare.

As a result of the meeting with the audit team, Information Services staff met with Vital Records staff to discuss the date of death discrepancies identified by the auditors that existed between our databases. Prior to the meeting with Vital Records, Information Services researched existing data match processes to ensure the error was not occurring with the TennCare Management Information System (TCMIS). The meeting revealed that TennCare was not receiving corrected records. Vital Records agreed to start providing corrected records monthly.

In addition to the death data reported on the Vital Records file, TennCare also receives referrals from various sources (i.e. TennCare Information Line) and receives suspect match reports from the Vital Records match process. TennCare was granted approval to access the State On Line Query (SOLQ) into the Social Security Administration file, which contains date of death information. SOLQ access has provided TennCare with a valuable tool in the research and validation of death data that is not confirmed through the Vital Records validation/match process.

The audit group provided TennCare with a listing of 4,378 enrollees whose Social Security number matched exactly to TCMIS Social Security Number. As a result of the omission of corrected records from the Vital Records file, Information Services staff accessed the Social Security Administration file (SOLQ) to verify the date of death provided by the audit team. The TCMIS was updated for enrollee records validated through SOLQ. According to staff's evaluation, not the auditor's review, SOLQ did not contain death information on 22% of the enrollees listed on the audit report. The audit finding is correct in stating that match criteria used by the auditors was less restrictive than the criteria used by TennCare for date of death matching and subsequent TCMIS updates. TennCare is required to utilize more restrictive match criteria

due to existing policy and court ordered requirements before termination of coverage. The percentage of non-matched records that occurred when the audit records were matched against the Social Security Administration database demonstrates why the more restrictive criteria should be used for automatic termination. The Director of TennCare Information Services has initiated discussions with appropriate TennCare Policy and Legal Staff to consider less restrictive data match criteria for the Vital Records matching process.

As a result of the TennCare Information Services manual efforts to react to the audit discovery, MCO capitation payments made from December 1997 through November 1998 for deceased enrollees were recovered in the December 1998 capitation check write representing approximately $5,000,000.

We partially concur with the report prepared by Internal Audit indicating that TennCare staff were not using system generated paid claims reports made on behalf of deceased enrollees. These reports were not being worked timely and are now being worked by Information Services staff. Procedures have been implemented to ensure recoveries based on date of death information occur more timely. Each month after the Vital Records update, reports are produced that identify all claims paid that are beyond the enrollees' death date. The claims identified are voided or adjusted accordingly.

TennCare does load death dates based on data obtained from Medicaid claims, however, eligibility coverage is not closed until validation from Vital Records occurs. MCO capitation payments are recovered when date of death information is loaded to the TennCare database regardless of Vital Records matching.

We do not concur that the capitation payments made to the BHOs identified in this finding cannot be recovered due to contract language. As explained to the auditors, reconciliation of previous monthly capitation payments has not occurred since July 1997 because of changes to the reimbursement methodology. We do concur that it is possible payment allocations to the two BHOs could have been affected. We will perform a review to determine whether the allocations should be adjusted.

Auditor's Comment

Auditors were told by the TennCare Director of Budget and Finance and the Department of Health's Director of the Office of Budget and Finance that capitation payments made to the BHOs could not be recovered from the BHOs.

"Management's Comment" states that MCO capitation payments made from December 1997 through November 1998 had been recovered in response to the audit discovery. However the comment did not address the auditors' recommendation that management investigate whether improper capitation payments had been made on behalf of deceased enrollees since the inception of TennCare, in January 1994. If it is determined that erroneous payments were made, management should pursue recovery of the payments.

Also, management did not respond to the auditors' recommendation that management consider using the encounter data to detect changes in recipient eligibility.

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10. TennCare failed to identify incarcerated youth and thus improperly used federal funds to pay their health care costs

Finding

As noted in the prior audit, because TennCare failed to identify incarcerated youth enrolled in the program, even though there are procedures to identify incarcerated adults, TennCare improperly paid for the health care costs of youth in the state's developmental centers. Under federal regulations (*Code of Federal Regulations*, Title 42, Section 435, Subsections 1008 and 1009), the state, not the federal government, is responsible for the health care costs of juvenile and adult inmates. Management concurred with the prior finding stating that they would work with the Department of Children's Services (Children's Services) to determine how they will ensure that procedures exist to prevent the billing of services provided to incarcerated youth. Although TennCare's management has met with Children's Services management, it appears that TennCare still has not taken sufficient action to implement effective procedures to prevent payments for incarcerated youth.

Using computer-assisted audit techniques, a search of TennCare's paid claims records revealed that TennCare made payments totaling at least $571,880.03 from July 1, 1997, to June 30, 1998, for juveniles in the youth development centers. Of this amount, $298,519.38 was paid to managed care organizations (MCOs); $107,661.26 was paid to behavioral health organizations (BHOs); and $165,699.39, to Children's Services. In addition, it was noted in the Children's Services audit that another $10,400 was paid on behalf of children in detention centers. A total of $474,618.77 is questioned.

The amount paid to the BHOs will not be questioned because they are paid based on a predetermined budget for mental health services approved by HCFA. Therefore, the total payments to the BHOs does not change regardless of the number of enrollees.

The payments to the MCOs were monthly capitation payments—payments to managed care organizations to cover TennCare enrollees in their plans. Since the bureau was not aware of the ineligible status of the children in the youth development centers, TennCare incorrectly made capitation payments to the MCOs on their behalf.

TennCare contracts with Children's Services to determine the eligibility of children under its care and should notify TennCare when these children are no longer eligible. However, Children's Services does not notify TennCare when previously eligible youth are incarcerated.

Since the bureau has no procedures, such as data matching, to check for such an eventuality, it was unaware juvenile inmates were on the TennCare rolls.

All known and estimated errors will be included on the Schedule of Findings and Questioned Costs in the Tennessee Single Audit report for the year ended June 30, 1998.

Recommendation

The Assistant Commissioner for TennCare should ensure the bureau develops and implements the procedures necessary to ensure federal funds are not used to pay for the health care costs of incarcerated juveniles. Management's top priority should be to pay only for eligible recipients. The Commissioner and the Assistant Commissioner for TennCare should ensure that the Director of Information Services designs and implements computer-assisted monitoring techniques to promptly detect ineligible enrollees. Amounts incorrectly paid should be recovered.

Management's Comments

We concur. TennCare staff have met with the Department of Children's Services on this subject and will be utilizing our monitoring agreement with the Department of Finance and Administration to examine internal controls over this area. In addition, we will pursue implementing computer-assisted monitoring techniques for detecting incarcerated youth.

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11. The TennCare Management Information System was not updated timely to process Department of Mental Health and Mental Retardation claims

Finding

Claims from the Department of Mental Health and Mental Retardation (DMHMR) for services provided during the 1997 fiscal year (July 1, 1996, through June 30, 1997) were not paid until September 1997 because TennCare management failed to process the system change request to update the procedure codes and the payment rates in the TennCare Management Information System (TCMIS).

DMHMR annually contracts with providers to render services to recipients in the Home and Community Based Services–Mental Retardation (HCBS–MR) Waiver program administered by TennCare. After services are performed, the providers bill DMHMR, which then, under the HCBS–MR waiver, files claims with TennCare to be reimbursed for services paid to the providers.

Testwork revealed that TennCare failed to reimburse DMHMR for services paid to the providers because all of the procedure codes and reimbursement rates were not updated on the TCMIS, as stated in the system change request, until March 1997. Therefore, DMHMR was unable to bill TennCare for reimbursement of approximately $59 million already paid to providers during the 1997 fiscal year, causing DMHMR to use state funds to reimburse providers. Apparently, poor communication between TennCare and DMHMR further delayed processing until the end of the 1998 fiscal year.

Recommendation

The Commissioner and the Assistant Commissioner for TennCare should ensure that the system change requests used to update the TennCare Management Information System are processed timely so as to avoid the unnecessary use of state funds when federal matching funds are available.

Management's Comment

We concur. TennCare will examine the procedures for implementing system change requests. One goal of the reorganization plan is to improve communication between the TennCare Bureau and other departments so situations like this will be less likely to occur.

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12. For the fourth straight audit, since July 1, 1994, the Director of Information Services did not provide information necessary to conduct audits of TennCare timely

Finding

During the prior three audits, covering the period July 1, 1994, through June 30, 1997, the Director of Information Services has not always provided the auditors with requested TennCare Management Information System (TCMIS) information timely. The Director also has not demonstrated a full understanding of and concern for the objectives of the audit and what is necessary for achievement of the objectives. Because the TCMIS is central to the function of the TennCare program, it is impossible to audit the TennCare program without obtaining critical information about the system and the data processed by the system. The Director is responsible for managing both the staff of the Division of Information Services and the contractor hired to maintain and operate the system. Therefore, the auditors must submit numerous requests for information to the Director.

As noted in the three prior audits, the auditors experienced significant delays (two months), or were not provided with critical TennCare recipient eligibility information. Because of these and other problems, at the start of this audit the auditors discussed their concerns about

audit delays in the area of Information Services with the Commissioner at the field entrance conference. At the Commissioner's request, a planning meeting was held with the Director to communicate the audit needs and address and identify the audit timetable. To help facilitate audit information requests, the Commissioner also assigned the Assistant Commissioner of the Office of Budget and Finance, as the audit liaison. Despite these efforts, the situation did not improve.

Typically, a variety of information-gathering techniques are used during the audit process, including inquiry, observation, and inspection. On occasion unannounced visits are necessary to accurately evaluate actual processes and operational conditions. Because the Director asked that many requests be submitted in writing, and that contact with the employees of the data processing contractor be arranged in advance through their supervisors, at times it was difficult or impossible to employ these standard auditing techniques. This is a concern because the contractor's employees perform critical TennCare functions on a daily basis.

In several instances, information was not provided or was not timely. Often it appeared that the Director's primary objective was to control the flow of information to the auditors rather than provide a free flow of information. For example, the Director refused to provide the auditors with the telephone listing for the data processing contractor; and other information requested in September 1998, had not been received by January 6, 1999. In addition, it took several requests and discussions to obtain an organization chart for the data processing contractor, which is located on-site in the TennCare building.

The auditors encountered communication problems as well. The Director did not take reasonable measures to seek clarification when he was uncertain of the exact information requested in writing. As a result, no information was received. Frequently telephone calls were not returned timely and/or they were returned after business hours. Delays also occurred on several occasions when employees in the Division of Information Services, who appeared apprehensive about answering the auditors' questions, declined to comment and referred the auditors to the Director.

Section 8-4-109, *Tennessee Code Annotated*, authorizes the Comptroller of the Treasury to audit any books and records of any governmental entity that handles public funds when the Comptroller considers an audit to be necessary or appropriate. The same section also states, "The comptroller of the treasury shall have the full cooperation of officials of the governmental entity in the performance of such audit or audits."

As discussed in the "Objectives, Methodologies, and Conclusions" section of the report, the audit of the Department of Health is part of the annual audit of the Comprehensive Annual Financial Report (CAFR) and the Tennessee Single Audit (Single Audit). The Single Audit is conducted in accordance with the Federal Single Audit Act, as amended in 1996. The Single Audit Act requires the auditors to determine compliance with rules and regulations, the existence and effectiveness of internal controls, and to report on these matters to the federal government. When information is not received timely, unnecessary delays in audit fieldwork and reporting can occur. Reporting delays can adversely affect management's ability to take prompt corrective

action. In addition, unnecessary delays drive up audit costs, which are paid for with state (50%) and federal (50%) funds.

In addition, accountability to top management, the legislature, the federal community, and the public is avoided when information required for the audit is not forthcoming. When access to information is tightly controlled or cannot be obtained, additional concerns about management's integrity and performance of the program are heightened.

Recommendation

The Commissioner should clarify who the Director of Information Services reports to and should ensure that he cooperates fully with the Office of the Comptroller and provides the infor-ation necessary to conduct the audit in a timely manner. This cooperation should also extend to other areas of the department.

Management's Comment

We concur in part. There were instances where the requested information was not provided on a timely basis. After discussions with the Director of Information Services, the new TennCare Director does not believe there was a deliberate effort by the Director of Information Services to frustrate the audit. Having worked with and observed the Director of Information Services' efforts, the new TennCare Director believes the untimeliness of data responses were due more to extraordinary demands from numerous sources, e.g. daily operational requirements, HCFA, MCO monitoring, and an antiquated MMIS than to the Director of Information Services' willingness to comply.

The report states the Director of Information Services requested requests be submitted in writing and that intrusion on employees' time be arranged in advance. Again, the antiquated system, extraordinary requirements and time needs necessitate a management, a control of the work effort.

The Bureau is committed to assisting the audit function, and all efforts will be made to provide readily available information immediately and to prioritize the audit team's requests according to other requirements.

As to the Director of Information Services returning phone calls after hours, we are not surprised. The Director of Information Services' workload requires extraordinary hours, much more than many other employees in state government.

The Director of Information Services is aware and has always performed his duties in a manner that indicated his awareness of who his immediate supervisor is. The TennCare Director will work closely with the Director of Information Services along with other Bureau staff to ensure timely response to auditors' requests. We recognize the necessity for periodic audits and

we will strive to make the data available to facilitate the audit in a timely manner. We appreciate the auditors' continued sensitivity to the incredible operational requirements of the TennCare Bureau.

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13. TennCare has not established a coordinated program for ADP risk analysis and system security review

Finding

As noted in the prior audit, TennCare does not have a coordinated program for ADP (automated data processing) risk analysis and system security review of the TennCare Management Information System (TCMIS). Management concurred with the prior year finding and stated that the Bureau was seeking guidance from the Health Care Financing Administration (HCFA) regarding their expectations for this regulation and would take steps to comply. Although the bureau has relied on the Department of Finance and Administration's Office for Information Resources (OIR) for security of TCMIS and the system operations are being analyzed and reviewed for the Year 2000 project, the Bureau has failed to comply with Federal regulations by not establishing a program for ADP risk analysis and system security review.

According to Office of Management and Budget (OMB) Circular A-133 and the *Code of Federal Regulations*, Title 45, Subtitle A Section 95.621, such an analysis and a review must be performed on all projects under development and on all state operating systems involved in the administration of the Department of Health and Human Services' programs. TCMIS is such an operating system and is one of the largest in the state.

The risk analysis is to ensure that appropriate, cost-effective safeguards are incorporated into the new or existing system and is to be performed "whenever significant system changes occur." The system security review is to be performed biennially and include, at a minimum "an evaluation of physical and data security operating procedures, and personnel practices."

If TennCare is to rely on TCMIS for the proper payment of benefits, a security plan, which includes risk analysis and system security review must be performed for this extensive and complex computer system. OMB Circular A-133 requires the plan to include policies and procedures to address the following:

- Physical security of ADP resources
- Equipment security to protect equipment from theft and unauthorized use
- Software and data security
- Telecommunications security
- Personnel security

- Contingency plans to meet critical processing needs in the event of short- or long-term interruption of service
- Emergency preparedness
- Designation of an agency ADP security manager

Recommendation

The Commissioner and the Assistant Commissioner for TennCare should ensure the Director of Information Services promptly develops and implements procedures for ADP risk analysis and system security review. The Assistant Commissioner should look to staff to take the initiative in analyzing and reviewing these important areas and not accept the excuse that HCFA may not have specific guidelines to justify staff not taking the necessary steps. The Commissioner should monitor the procedures implemented and ensure the appropriate actions have been taken.

Management's Comment

We concur. However, TCMIS has been reviewed by the Health Care Financing Administration (HCFA) since the implementation of TennCare, and this issue was not raised as a concern. We have asked HCFA for guidance regarding their expectations from states regarding this regulation and will take steps to comply with their response. Additionally, TCMIS is included in the Office of Information Resources' disaster recovery plan and security controls.

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14. TennCare failed to identify ineligible incarcerated youth resulting in the loss of approximately $55,000 in federal matching funds

Finding

TennCare incorrectly allocated behavioral health organization (BHO) contract payments because they failed to identify ineligible incarcerated youth. As a result, the state lost approximately $55,000 in federal matching funds.

TennCare makes contract payments to BHOs for eligible individuals. The Health Care Financing Administration requires TennCare to allocate these contract payments between basic mental health services and enhanced services. If an individual needs enhanced services, he is classified as Severely and Persistently Mentally Ill (SPMI) (adults) or Seriously Emotionally Disturbed (SED) (children) and a higher fixed rate is allocated to the BHOs. The federal match is only available for the basic services and the enhanced services up to 60 days. After 60 days, the enhanced services must be funded with state dollars.

Because TennCare failed to appropriately identify ineligible incarcerated youth (see finding 10), some of whom were classified as SPMI/SED over 60 days, there were more SPMI/SED enrollees over 60 days not eligible for the federal match. Using computer–assisted audit techniques, it was determined that TennCare paid 269 of these payments for ineligible enrollees at the enhanced rate of $319.41. Therefore, a total of $85,921.29 was paid with state dollars only. If TennCare had not included these ineligible enrollees, the federal matching funds of approximately $55,000 for the remaining eligible population would not have been lost.

Recommendation

The Commissioner should ensure that the Bureau identifies incarcerated youth in order to allocate contract payments properly and recoups the excess funds paid by the state, if possible. The Commissioner and the Assistant Commissioner for TennCare should ensure the Director of Information Services designs and implements computer-assisted monitoring techniques to promptly detect ineligible enrollees.

Management's Comment

We concur in part. As stated in our response to finding number 10, we are coordinating with the Department of Children's Services to develop better controls over this area. With better controls in place at the Department of Children's Services and monitoring by TennCare, the risk of this occurring again will be reduced.

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15. Because of uncollected cost settlements, TennCare has remitted $11.8 million in state dollars to the federal government

Finding

As noted in the past two audits covering July 1, 1995, through June 30, 1997, because TennCare has failed to collect Medicaid cost settlements from providers, state dollars have been used to pay the federal portion of the cost settlements. (A cost settlement due the state can occur if the annual review of a provider's cost report discloses that the cost of services or charges for services were less than the payments the provider received.) The federal grantor, the Health Care Financing Administration (HCFA), requires the state to remit the federal share (approximately two-thirds) within 60 days of settlement, whether or not the state has collected the amounts due from the providers.

TennCare pursues collection of the cost settlement receivables before and, if necessary, after the federal share of the cost settlement receivables has been remitted to HCFA. Management concurred with the prior findings and stated that staff "has aggressively pursued

reducing the outstanding cost settlement balances." However, compared to the amount reported in the prior year, little improvement has been made. At June 30, 1998, the cost settlements over 60 days late were $13,971,688.71. Furthermore, in November 1998, they had risen to $17,798,717.60. Approximately two-thirds ($11.8 million) of this amount has been returned to the grantor, using state funds.

According to TennCare's records, two hospitals had the largest overdue cost settlement balances at November 13, 1998—Regional Medical Center at Memphis ($3,924,954.60) and George W. Hubbard Hospital of Meharry College in Nashville ($2,916,487). Management is uncertain whether the Regional Medical Center at Memphis has the resources to pay its cost settlements and indicated that the hospital has questioned various aspects of its settlements.

According to bureau personnel, legal questions about Hubbard Hospital's current operating status have impeded collection. Also, the current audit revealed that Meharry Medical College has asserted that TennCare (Medicaid) owes the school approximately $2.7 million for unreimbursed prior year costs at Hubbard Hospital.

Because of the difficulty collecting cost settlements directly from providers, in cooperation with the Medicare program administered by the federal government, TennCare initiated garnishment of providers' Medicare payments. However, TennCare has refrained from asking Medicare to garnish all of the outstanding cost settlement receivables until the two financial information systems containing provider balances—TennCare Management Information System(TCMIS) and the Medicaid Accounts Receivable Recoupment System—can be reconciled. (This matter is discussed further in finding 6.)

Although management has delayed requests to Medicare and the financial information from the Recoupment System is questionable, TennCare management has used this information to remit amounts and report quarterly to HCFA.

Management stated that it was also exploring having the Department of Finance and Administration use STARS to withhold other departments' and agencies' payments to providers. Section 9-4-604, *Tennessee Code Annotated*, provides authority for this procedure:

> No person shall draw any money from the public treasury until all debts, dues, and demands owing by such person to the state are first liquidated and paid off. The commissioner of finance and administration shall not issue any warrants upon the treasury in favor of a person in default until all of such person's arrearages to the treasury are audited and paid.

In fiscal year ending June 30, 1998, TennCare had requested that the Department of Finance and Administration withhold payments to only one provider, collecting $6,409.39. Considering the approximately $17.8 million owed, TennCare's failure to pursue this avenue more aggressively is incomprehensible and contrary to statute.

It is in the state's best interest to resolve the cost settlement accounts receivable as quickly as possible through collection or write-off after all other efforts have been exhausted. Using state funds to remit the providers' share to HCFA deprives the state of the use of these funds. If the state determines that some of the accounts are uncollectible and the accounts are written off, the state may, in certain cases, recover what has already been remitted to HCFA.

Recommendation

To recover the state funds that have been remitted to the federal grantor, the Assistant Commissioner and the Fiscal Director for the TennCare Bureau should ensure that all outstanding cost settlements are collected or written off in a timely manner. When accounts are written off, management should take the necessary steps to obtain a refund from the grantor for the amounts remitted using state funds.

Management should take immediate measures to resolve any questions concerning the amounts owed and each provider's ability to pay. If necessary, assistance from the Office of the Attorney General should be obtained. The Fiscal Director should continue to contact the Department of Finance and Administration about withholding additional payments through STARS.

Management's Comment

We concur. However, since the inception of TennCare, the TennCare staff has aggressively pursued reducing the outstanding cost settlement balances through additional billing correspondence, legal assistance, and other available offsets. After following the appropriate procedures, TennCare has written off those accounts determined uncollectible, including when a provider has filed bankruptcy and the court has upheld the bankruptcy. We have referred providers to Medicare when possible and will continue to do so. We are exploring options with the Department of Finance and Administration for alternate collection methods. We continue to reconcile balances and are working with the Director of Information Services to make system modifications to alleviate the reconciliation issues.

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16. TennCare did not adequately verify enrollment application information for cross-over and nursing home providers or monitor the enrollment of providers by the Department of Children's Services

Finding

As noted in the previous audit, professional cross-over and nursing home providers were not verified or updated in TennCare's enrollment process nor was the Bureau monitoring the

enrollment of providers by the Department of Children's Services (Children's Services). Management concurred with the finding stating that greater verification of eligibility needs to occur for those providers that do not participate in the Medicare program. The bureau also indicated that the availability of licensure information on the Internet should provide for verification of provider eligibility for all future providers. TennCare personnel also agreed to review provider eligibility verification with Children's Services. While management established verification procedures for provider information, these procedures were not implemented timely. Therefore, the Bureau could not assure proper enrollment and adequate verification for all cross-over and nursing home providers.

New enrollment procedures were implemented in May 1998 that established verification procedures for cross-over and nursing home provider information. Cross–over providers are those physicians whose claims are partially paid by both Medicare and Medicaid. For participation in the TennCare/Medicaid program, providers must now submit, along with the appropriate application, a copy of their Tennessee license or a copy of the latest renewal and information on affiliations with medical groups. The Bureau's Provider Enrollment Unit must perform a verification of the application. While these procedures have significantly improved the enrollment process since implementation, a problem still exists because management did not execute these procedures until late in the fiscal year.

According to TennCare personnel, providers that were enrolled in TennCare prior to May 1998 are not updated systematically for current licensure and possible license suspensions, criminal convictions, etc. Any termination information received on the these providers usually comes from Medicare, which TennCare does not automatically receive, and may not arrive in time to stop payments to the provider.

Testwork revealed that 15 of 60 (25%) providers were not accurately enrolled in the TennCare Management Information System (TCMIS). Ten of the 15 providers improperly enrolled did not have a license number recorded on TCMIS, four of the providers had license numbers on TCMIS that did not agree with Health Related Boards, and one provider was not enrolled in TCMIS, although the group to which he belonged was enrolled. Apparently, these providers were enrolled prior to the establishment of the new enrollment procedures.

TennCare has ultimately relied on Medicare for the verification of provider eligibility information for both cross-over and nursing home providers and on Children's Services' providers for children in state custody. Medicare's application process is much more extensive than that of TennCare and, apparently, applications are thoroughly reviewed. TennCare personnel stated that since most providers are already participants of the Medicare program and Medicare's resources for verification are extensive, the bureau's reliance on Medicare for enrollment is sufficient for compliance with rules and regulations.

Additionally, TennCare has not monitored to ensure the service providers used by Children's Services are eligible to participate in the TennCare/Medicaid program. Children's Services contracts with these providers for therapeutic services for the children under its

supervision, and ultimately bills TennCare for these services. See finding 3 for more information about Children's Services' service providers and billings to TennCare.

According to the Rules of the Tennessee Department of Health, section 1200-13-12-.08, "Bureau of TennCare," participation in the TennCare/Medicaid program is limited to providers that "maintain Tennessee licenses and/or any certifications as required by their practice, or licensure by the Tennessee Department of Mental Health and Mental Retardation." The Rules go on to state that participation is limited to providers that "are not under a Federal Drug Enforcement Agency (DEA) restriction of their prescribing and/or dispensing certification." Additionally, Office of Management and Budget (OMB) Circular A-133 requires that the state plan "specify criteria for determination of validity of disbursed payments" and that the state ensure payments "are disbursed only to eligible providers."

Recommendation

The Commissioner, the Assistant Commissioner for TennCare, and the Director of Operations should ensure that enrollment verification procedures are properly followed. Also, management should ensure update procedures for all provider information are established to assure that all providers remain eligible and assign the implementation of such procedures to the TennCare Provider Enrollment staff. The Commissioner and Assistant Commissioner should ensure that Children's Services is monitored to ensure all service providers are eligible to participate in the program. Management should ensure that the information is verified, updated, and maintained by either Children's Services or the TennCare Provider Enrollment staff.

Management's Comment

We concur. We will examine the procedures for enrollment verification and develop remedies for the deficiencies noted. An aggressive approach for verification and reverification is a key element of the Bureau's strategic plan. We have arranged for the Department of Finance and Administration to assist us in monitoring several aspects of the Department of Children's Services and will include provider enrollment in that review.

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17. TennCare does not effectively monitor the eligibility of Supplemental Security Income (SSI) recipients

Finding

TennCare does not have an effective method to monitor the eligibility of TennCare/ Medicaid recipients who are eligible because they receive Supplemental Security Income (SSI). The Rules for the Tennessee Department of Health, Bureau of TennCare, section 1200-13-12-.02

1(c) state, "the Social Security Administration (SSA) determines eligibility for the Supplemental Security Income (SSI) program. In Tennessee, SSI recipients are automatically eligible for Medicaid. All SSI recipients are therefore TennCare eligibles."

Testwork revealed that of nine SSI recipients, one recipient apparently became ineligible for TennCare and other state/federal benefits in December 1995 when she moved her residence out-of-state. However, the TennCare Bureau took 18 months (until June 1997) to identify this individual, detect ineligibility, and proceed with disenrollment. According to statements from TennCare personnel, the Bureau cannot disenroll an SSI individual and discontinue managed care organization and behavioral health organization capitation payments until adequate information indicates that eligibility is no longer met.

TennCare personnel stated that reports from SSA are manually worked to verify information such as out-of-state addresses. To verify addresses, TennCare personnel compare addresses on TCMIS against the Department of Human Services' and SSA's systems. Written notification from the enrollee is also accepted as verification. Although TennCare did not receive immediate notification of out-of-state residency for the above individual, the manual verification procedures that TennCare performs with the SSA should have provided for earlier detection of the ineligibility of the individual.

Because the individual was not disenrolled from TCMIS timely, TennCare paid excess capitation payments in the amount of $968.29 to a managed care organization and $249.40 to a behavioral health organization. According to Office of Management and Budget (OMB) Circular A-133, payments are only allowed for individuals who are eligible for the TennCare/Medicaid program. These costs will be questioned in the Schedule of Findings and Questioned Costs in the 1998 Tennessee Single Audit Report.

Recommendation

The Commissioner and the Assistant Commissioner for TennCare should ensure the Director of Information Services designs and implements computer-assisted monitoring techniques to promptly detect ineligible enrollees. Once ineligibility is established, management should make timely efforts for proper disenrollment.

Management's Comment

We concur in part.

The enrollee referenced in the audit finding was referred to the TennCare Information Services Section for termination by DHS. DHS had obtained information that the enrollee was no longer residing in Tennessee. During the review period, Information Services relied on DHS' verification of SSI enrollees receiving benefits in another state. TennCare did not have on line access into the Social Security Administration's State On Line Query (SOLQ) that houses SSA

data until April 1998. This database is the source for verification of SSI benefits. The Director of TennCare Information Services and his staff worked with the Social Security Administration to obtain inquiry access to the State On line Query System. The SSA has very stringent RACF security procedures that must be adhered to for all SOLQ activities. TennCare received formal authorization from the Social Security Administration in March 1998 for access into SOLQ.

TennCare and DHS have strict rules regarding terminations of SSI enrollees which are stipulated as a result of the "Daniels" Court order decree. The rules allow termination of SSI enrollees only if the State verifies they are deceased or receiving benefits in another state. Access directly into SOLQ has eliminated TennCare's dependency on DHS for verification of benefit information, which now allows us to directly investigate and take termination action as needed. This will enable us to react more timely for disenrollment of SSI enrollees in accordance with TennCare Policy and Procedures. The Information Services Section continues to review system generated reports to identify SSI enrollees with out of state addresses.

Audit finding 9 detected a problem in the identification of deceased enrollees based on matches with Vital Records files. A procedure has been implemented to provide corrected death records each month.

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18. TennCare used memorandums of understanding to disburse payments to medical schools

Finding

As noted in the previous audit, TennCare did not use an appropriate type of agreement for graduate medical education (GME) payments. Instead of abiding by the Rules of the Department of Finance and Administration, Chapter 0620-3-3, "Personal Service, Professional Service, and Consultant Service Contracts," and establishing multi-year grant contracts, TennCare entered into memorandums of understanding (MOUs). Management concurred with the prior audit finding and stated that it was not in compliance with contract rules and state laws. They further stated that the current memorandums of understanding would expire in December 1998, and at that time the agreements would continue via state contracts. However, as of January 27, 1999, TennCare had not entered into the required state contracts.

In June 1996, the Health Care Financing Administration (HCFA) approved TennCare's five-year plan for determining and disbursing GME payments to the four medical schools in the state—East Tennessee State University, the University of Tennessee at Memphis, Meharry Medical College, and Vanderbilt University. The approved plan was for payments each fiscal year from July 1, 1995, through June 30, 2000. Subject to the availability of state and federal funding, total annual GME expenditures are expected to range from $48 million for fiscal year June 30, 1998, to $53,566,000 for fiscal year June 30, 2000.

According to information from the Office of Contracts Administration, Department of Finance and Administration, the type of agreement under which TennCare disbursed these funds was not an acceptable mechanism. The appropriate mechanism would have been multi-year grant contracts. These contracts are developed to safeguard the interests of the department and the state, ensure compliance, and effectively communicate the rights, responsibilities, and obligations of all parties.

In addition, the MOUs (and amendments) were not signed by the Comptroller of the Treasury, as required by *Tennessee Code Annotated*, Section 12-4-110 paragraph (a)(1), "Contracts calling for expenditures from appropriations of more than one (1) fiscal year must also be approved by the comptroller of the treasury." These agreements were, however, signed by the Commissioner of Finance and Administration.

Recommendation

The Assistant Commissioner should comply with all state laws and rules for contracts. Each school's memorandum of understanding should be replaced with a multi-year grant contract signed by all parties and approved by the Commissioner of Finance and Administration and the Comptroller of the Treasury. No payments should be made before these contracts are finalized.

Management's Comment

We concur. The Bureau has entered into grant contracts with GME fund recipients effective for the period January 1, 1999. These contracts have been executed and are loaded into the STARS system.

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19. TennCare has not monitored the graduate medical schools

Finding

TennCare has not monitored the graduate medical schools to ensure requirements related to graduate medical education (GME) payments are met, nor has TennCare advised the graduate medical schools of the audit requirements of subrecipients. GME payments are made to the state's four medical schools and consist of three components: a hospital pass-through component, a primary care allocation component, and a resident stipend component. The hospital pass-through funds are paid to the medical schools, which are required to allocate the funds to the hospitals designated in the GME plan. Under the primary care allocation, the GME dollars are to follow the residents to their sites of training. The amount of each school's primary care component is determined based on the lists of residents provided by the medical schools. The stipend component is awarded to a resident in family practice, internal medicine, pediatrics, or

obstetrics during the years of residency for which the resident agrees to participate and to serve TennCare enrollees in a "Health Resource Shortage Area" of Tennessee. During the year ended June 30, 1998, GME expenditures were approximately $48 million.

TennCare does not monitor the graduate medical schools to ensure the following:

- The hospital pass-through component dollars paid to the hospitals designated in the GME plan are properly allocated.
- The lists of residents used to determine the primary care component are valid.
- The graduate medical schools have taken appropriate action to correct federal compliance audit findings.

Although TennCare relies on the graduate medical schools to comply with the terms of their agreement, the bureau does not monitor the graduate medical schools to ensure requirements are met.

Office of Management and Budget (OMB) Circular A-133 requires the department to monitor subrecipients' activities to provide reasonable assurance that the subrecipients administer federal awards in compliance with federal requirements. OMB Circular A-133 also requires the department to ensure that required audits are performed and that subrecipients take prompt corrective action on any audit findings.

The department cannot determine subrecipients' compliance with applicable laws and regulations if appropriate monitoring procedures are not performed and required audits are not obtained. Furthermore, funds could be used for objectives not associated with the grant and subrecipient errors and irregularities could occur and not be detected.

Recommendation

TennCare should immediately advise the subrecipients of the audit requirements for subrecipients of federal funds. The Assistant Commissioner for TennCare should establish a monitoring program to ensure compliance with grant requirements. All monitoring should be sufficiently documented and deficiencies should be promptly reported to the graduate medical schools. TennCare should also require the schools to submit corrective action plans.

Management's Comment

We concur. The Bureau will advise the subrecipients of the audit requirements for subrecipients of federal funds. The medical schools have been included in the contract monitoring plan submitted to the Department of Finance and Administration in accordance with Policy 22.

20. Policies and procedures for accounts receivable and accrued liabilities need improvement

Finding

TennCare's policies and procedures for accounts receivable and accrued liabilities are not adequate. Because of these inadequacies, numerous deficiencies in TennCare's accounts receivable and accrued liabilities records were noted.

As part of the state's year end financial closing procedures, management determines, and then records in the State of Tennessee Accounting and Reporting System (STARS), the accrued liabilities for the TennCare program. For the fiscal year ended June 30, 1998, the total amount of TennCare's accrued liabilities recorded in STARS was $265,312,552.

Management obtained and recorded estimated accrued liability amounts from the Department of Children's Services (Children's Services), the Department of Mental Health and Mental Retardation (DMHMR), and the Medicaid/TennCare Section of the Comptroller's Office. However, management did not obtain and review sufficient supporting documentation for the amounts recorded, nor did they get assurance from these departments that the liability balances were accurate. With one exception, TennCare management could not provide worksheets or any other support for the amounts recorded.

Our audit of Children's Services determined that the $42.4 million accrued liability for that department could not be supported and most likely was overstated. However, because of deficiencies in Children's Services' accounting records the correct amount of the liability could not be determined.

Because TennCare's Accounting Manager could not provide support for the TennCare-related accrued liabilities for DMHMR, the auditor was told to obtain the information from the Fiscal Director at DMHMR. As a result of the audit testwork, adjustments to the accrued liabilities for DMHMR were proposed. As noted in finding 1, without a clear delineation of the organizational structure of the Departments of Health and Mental Health and Mental Retardation, management cannot be assured of reliable financial reporting.

Testwork also revealed that Medicaid provider cost settlement receivables and payables were netted improperly. Cost settlement receivables and cost settlement payables were netted by category (e.g., hospitals, long term care facilities). For example, "hospital receivables" were netted with "hospital payables," instead of by individual hospital. In addition, all total net amounts, by category, also were netted together.

Medicaid provider cost settlement receivables were not treated consistently. Only some of the receivables were recorded in STARS—indirectly, when they were netted with cost settlement payables. Management did not record (i.e., include in the net amount) cost settlement receivables accounted for on the Medicaid Accounts Receivable Recoupment System. (The problems with this system are discussed in greater detail in finding number 6.)

Furthermore, testwork revealed that TennCare's management has not developed written policies and procedures for recording accounts receivable in STARS or for monitoring, collecting, and writing off accounts receivable. Management considers many of the receivables uncollectible and, except for some of the cost settlement receivables discussed previously, does not record them in STARS. The types and amounts of receivables are as follows:

- TennCare enrollee premium receivables—The total outstanding balance at November 9, 1998, was $18,878,463.
- Fraud and abuse receivables, which result from fraud and abuse investigations—At June 30, 1998, the total outstanding balance was $3,176,884.
- Drug rebate program receivables that remain from the Medicaid program, prior to TennCare—The total outstanding balance at June 30, 1998, was $2,534,190.
- Provider cost settlements receivables owed by Medicaid providers, such as hospitals and nursing homes—See finding 15 for more information about these receivables.
- "PA-68" receivables established in the names of recipients to collect payments to providers that should have been paid by recipients—At June 30, 1998, the total outstanding balance was $51,730.

According to management, no effort has been made to collect the drug rebate program receivables since 1995, and no effort is made to collect enrollee premium receivables after a recipient is terminated from TennCare.

Proper accounting policies and procedures ensure that the financial information used for decision-making and state and federal reporting is accurate. In addition, good accounting policies and procedures result in audit resources being used more efficiently and effectively because of the reduced amount of time required to audit the financial records. Comprehensive written policies and procedures help staff carry out their job responsibilities and help ensure that accounting and reporting is consistent, which may result in improved management oversight and program financial performance.

Recommendation

The Commissioner should ensure the Fiscal Director obtains accurate and sufficiently detailed supporting documentation for amounts which will be recorded in STARS. In addition the Fiscal Director should ensure liabilities accrued by his office are carefully prepared and reviewed. This information should be provided to the auditors upon request.

The Fiscal Director also should ensure that receivables and payables (liabilities) are accounted for separately and consistently. Amounts should be netted on an individual provider or account basis only, if deemed necessary. The Fiscal Director should develop and implement written policies and procedures for monitoring, collecting, recording in STARS, and writing off TennCare's accounts receivable.

Management's Comment

We concur. We will begin the process of developing policies and procedures for monitoring, collecting, recording in STARS, and writing-off TennCare's accounts receivable. These policies and procedures will include obtaining and retaining accurate documentation of accrued liabilities.

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21. TennCare has failed to follow its own rules and has failed to revise its rules

Finding

As noted in the prior two audits, the Bureau of TennCare has ignored several of the departmental rules it created or has acted before rules were developed. Among the reasons cited for bypassing the rules were that some of the rules were out-of-date and no longer addressed the situation and that adherence to some of the rules was not feasible. Management concurred with the prior two findings and stated that the rules would be reviewed and revised as determined necessary. However, little or no progress has been made.

Tennessee Code Annotated prescribes the method for adopting departmental rules. Except for emergency or public-necessity rules, an agency must publish its proposed rule in the Secretary of State's monthly administrative register and include the time and place of a hearing on the rule. The legality of all proposed rules, including emergency and public-necessity, must be approved by the Attorney General and Reporter. Emergency and public-necessity rules are effective upon filing with the Secretary of State and other rules are effective 75 days after filing.

- Even though the bureau has contracted to make adverse selection payments to those managed care organizations with a disproportionate share of enrollees requiring extensive health services, and has made $170 million in such payments, the bureau has not established rules concerning these types of payments. The contracts, which obligate the state to pay up to $55 million annually, do not specifically describe how the payments will be calculated; they only state that the payments will be made using a formula developed by TennCare and approved by the Health Care Financing Administration.
- The bureau is paying some providers more than is allowed by departmental rules. The method used to calculate outpatient hospitalization payments to providers caring for enrollees who are both TennCare and Medicare recipients sometimes results in payments that exceed limits. (See finding 7 for more details.)
- The bureau has not revised its rules to include changes in the method it uses to determine payments to the state's medical schools for graduate medical education.

- The rules pertaining to the Home and Community Based Services waiver program have not been revised to reflect changes in the program. For example, TennCare no longer pays provider claims based on a per diem rate.

Generally, rules are used to state a department's position on important matters, provide standard definitions of technical words and phrases, and define regulations and policies that affect parties outside state government. Departmental rules are to be developed in an open forum, using due process, so that the interests of all concerned parties can be considered.

Recommendation

The Assistant Commissioner for TennCare should exhibit a strong commitment to the importance of up-to-date rules and the necessity of complying with rules. TennCare management and staff should comply with the bureau's rules, and the Assistant Commissioner should take appropriate measures, including a system for monitoring relevant program changes, to ensure that the rules are revised to remain current. The Assistant Commissioner should recognize that when rules are out of date, the department has failed to stay abreast of changes and has failed to appropriately tie rules to the operational aspects of programs. The Assistant Commissioner should recognize that when rules are not feasible, the process of developing the rules and ensuring they compliment and facilitate operations has failed. These situations should be avoided when possible, and if they do arise, they should be corrected immediately.

Management's Comments

We concur. During 1997, the Bureau and the Office of General Counsel began an extensive review of the TennCare rules to identify rules that needed to be revised to reflect current policy. From January 1998 until the present, twenty-nine rules have either been adopted or set for hearing including three rules pertaining to home and community based services waivers. We will continue to review the departmental rules for areas that need revision including those areas noted in the finding.

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22. For nine months TennCare inappropriately reimbursed the Department of Children's Services for employees on administrative leave with pay resulting from disciplinary actions

Finding

TennCare inappropriately reimbursed the Department of Children's Services (Children's Services) for two caseworkers' salaries for nine months while they were on administrative leave with pay resulting from disciplinary actions. Eventually one employee was placed in another

position with Children's Services, and the other employee was terminated. A contract between TennCare and Children's Services allows TennCare to reimburse Children's Services for administration of health-related services to TennCare-eligible children served by Children's Services. These administrative services include caseworkers who will coordinate and provide for access to health-related services to TennCare-eligible children, including emergency assistance determinations.

In accordance with an administrative cost allocation plan approved by Children's Services and TennCare, Children's Services bills case management salaries to the Bureau of TennCare and these costs are charged to the TennCare program.

When Children's Services removed two caseworkers from normal duties and placed them on administrative leave with pay, they did not notify the Bureau of TennCare of the situation. In addition, Children's Services failed to promptly resolve the situation and return the employees to normal duties or terminate them. As a result, TennCare reimbursed Children's Services for $18,072 of salaries for these two employees (approximately 9 months each). While on administrative leave with pay, the caseworkers were not providing any administrative services to the Bureau of TennCare or any other services to the state and, therefore, their salaries were inappropriately charged to the federal program. Of the total expenditure, $11,628 of federal funds will be a questioned cost on the Schedule of Findings and Questioned Costs in the 1998 Tennessee Single Audit Report.

Because Children's Services did not act promptly to resolve the disciplinary issues, Children's Services and the Bureau of TennCare misused federal and state funds.

Recommendation

The Assistant Commissioner for TennCare should work with the Commissioner of the Department of Children's Services to ensure that staff bill only appropriate charges to the Bureau of TennCare. The Assistant Commissioner should require the Department of Children's Services to notify the Bureau when employees whose salaries are charged to TennCare are placed on administrative leave with pay. TennCare should monitor these situations to ensure they are resolved timely by the Department of Children's Services.

Management's Comment

We concur. The Department of Health has entered into an agreement with the Department of Finance and Administration for monitoring of TennCare related activities at the Department of Children's Services. The monitoring will include an examination of internal controls over billings to the TennCare program.

23. TennCare should seek clarification of grant requirements

Finding

As noted in the prior two audits, modifications to TennCare's grant requirements are often necessary because TennCare is a relatively new approach to Medicaid for both the state and the Health Care Financing Administration (HCFA). However, the intent of some requirements becomes unclear with the changes. The payment rates for certain psychiatric services is one such case. Although, management concurred with the prior finding and stated they would contact the appropriate HCFA representative to obtain clarification, no evidence of this contact has been provided.

When TennCare began, mental health services were not immediately moved into a managed care setting as were other health services. As a result, the state requested permission from HCFA to continue to pay for some mental health services on a fee-for-service basis. The November 18, 1994, approval letter from HCFA states:

> For both the Children's Plan [Department of Children's Services] and the SPMI [severely and persistently mentally ill], retroactive payments to January 1, 1994, will be permitted on a fee-for-service (FFS) basis, subject to the State's processing these claims through the State Medicaid Management Information System that was in place prior to January 1, 1994, at the previously existing rates....(emphasis added)

Without seeking guidance from HCFA, TennCare interpreted this waiver as allowing the state to continue to adjust for inflation SPMI and the Department of Children's Services (Children's Services) rates for psychiatric hospitals and community mental health centers as it had done under Medicaid. During fiscal year 1995, TennCare also adjusted these rates to cover additional costs, such as capitalization of fixed assets and property taxes, and enhanced the rates by a Medicaid "disproportionate share factor" to help cover hospital charity costs. Prior to TennCare, these costs and the disproportionate share factor were not a part of the rates.

On July 1, 1996, TennCare implemented the TennCare Partners Program to provide mental health services in a managed care setting and discontinued fee-for-service payments for SPMI. Children's Services, however, continues to be paid with adjusted rates on a fee-for-service basis.

Although management agreed that all policies and programs and resulting payments should comply with grant requirements, management has not obtained documentation from HCFA regarding its position on the adjusted rates. During audit fieldwork, the Fiscal Director of TennCare stated that HCFA had verbally approved the adjusted rates. However, the Fiscal Director did not request formal written approval until December 1998, two years after the auditor's request. As of February 10, 1999, TennCare has not received the approval letter from HCFA.

Recommendation

The Assistant Commissioner for TennCare should immediately follow up with HCFA to obtain formal written approval for the adjusted rates. The Assistant Commissioner should also ensure that all policies or programs and resulting payments comply with grant requirements. If these requirements are unclear or if a substantial change is made, TennCare should seek guidance from the grantor before implementing the change.

Management's Comment

We concur. TennCare has contacted HCFA officials on this matter and is awaiting a response.

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24. Since fiscal year 1994, TennCare has not returned Medicaid refunds to the federal grantor promptly

Finding

For the past five years, from July 1, 1993, through June 30, 1998, TennCare has not promptly used the amounts recovered from third parties to reduce federal drawdowns. Management concurred with the prior audit findings and stated they would, "continue to work with the Department of Finance and Administration to further improve the timely processing of refund transactions that affect the federal draw of funds." In addition, management of the Department of Finance and Administration concurred and has taken measures "to ensure that HCFA remittances are properly identified and prompt approval and processing occurs." However, the timeliness of remittances to HCFA has not improved. Occasionally, refunds were delayed up to four weeks before remittance to HCFA. Based on reports provided by the department, refunds totaling $12,527,527.97 were deposited in fiscal year 1998. Our review of $5,193,005.23 of refund deposits disclosed that $3,309,288.08 was not remitted to HCFA in a timely manner.

The timeliness of remittances to HCFA involves two components: TennCare's prompt keying of information into STARS and the Division of Accounts' (within the Department of Finance and Administration) prompt approval to process the transactions.

The Cash Management Improvement Act Agreement holds the state liable for interest on refunds from the date the refund is credited to a state account until the date the refund is subtracted from drawdowns. Both TennCare and Department of Finance and Administration personnel indicated that the interest is properly remitted.

Recommendation

Both TennCare and the Department of Finance and Administration should coordinate efforts to determine why remittances are not timely and take immediate action to correct the delays. The Assistant Commissioner for TennCare should ensure refund transactions are promptly entered into STARS and forwarded to the Department of Finance and Administration. TennCare staff should continue to communicate the priority of processing these refund transactions and monitor them until drawdowns are reduced.

Management's Comments

Department of Health, Bureau of TennCare:

We do not concur. As stated in Finance and Administration Policy 20, all grant related revenue and expenditure transactions are coded to utilize the STARS grant module for draw-down purposes. TennCare has taken steps to identify transactions that are related to the Cash Management Agreement in order to aid the Department of Finance and Administration in prioritizing processing. It should be noted that the Cash Management Agreement's interest assessment calculations are designed to keep transactions between the federal government and the state on an interest neutral basis. Any interest assessed is to compensate the federal government for interest the state earned on any funds not remitted to HCFA timely and therefore, interest that is assessed represents funds the state would not have had if the funds had been remitted timely.

Department of Finance and Administration:

We do not concur. TennCare is complying with the terms of the Treasury State Agreement using the Post Issuance Funding Technique. TennCare is also complying with Policy 20. In the event that transaction volume is high or processing is slow due to staff turnover, processes are in place to remit any interest liability owed to the federal government if transactions are not processed timely. The interest liability that was incurred was immaterial considering the size of the TennCare program.

Auditor's Comment

It is the auditors' understanding that Medicaid refunds should be returned promptly to the federal grantor by reducing federal drawdowns. Testwork revealed that 28 of 44 refunds (64%) were not keyed into STARS within one day by the TennCare Bureau and 42 of 48 of the refunds (88%) were not processed by the Department of Finance and Administration within four days of receipt from the Bureau.

25. Controls over manual checks have been weak since 1994

Finding

As noted in the prior four years, July 1, 1994, through June 30, 1998, and despite management's concurrence with the findings, the TennCare Bureau needs to continue to improve controls over manually prepared checks. In fiscal year 1998, these checks totaled approximately $315 million.

The fiscal agent assigned responsibility for preparing these checks did not sufficiently segregate manual check-preparation duties. During the audit period, one employee had access to both the manual check stock and the signature stamp and could have controlled the process from beginning to end and issued a check for unauthorized purposes.

The only compensating control used was a reconciliation of checks issued and cleared each month. This reconciliation involves records from the Department of the Treasury (Treasury), the Department of Finance and Administration's Division of Accounts, and TennCare. This reconciliation ensures that TennCare's and Treasury's records of checks issued and cleared correspond to STARS. However, the reconciliations were not completed in a timely manner. As of June 1998, reconciliations had been performed only through April 1998.

Effective internal controls require that no one person have the ability to control the entire check-issuance process and that reconciliations of accounting records to bank activity be timely.

Recommendation

The Assistant Commissioner for TennCare should ensure duties are adequately segregated. In addition, each month, the Department of the Treasury, the Division of Accounts, and TennCare should reconcile checks issued and cleared with Account Reconciliation Package (ARP), STARS, and TCMIS records.

Management's Comment

We concur. We will continue to improve controls over manual checks and the timeliness of the reconciliation of checks issued with ARP, STARS, and TCMIS.

SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS, AND CHILDREN (WIC)

To address the objectives of the CAFR and the Single Audit, as they pertain to this major federal financial assistance program, we interviewed key department employees, reviewed

applicable laws, regulations, policies and procedures, and tested representative samples of transactions. Our specific objectives were to determine whether

- WIC voucher reconciliation procedures are adequate,
- program participants were eligible for services,
- federal funds were spent only for allowable purposes,
- equipment purchases charged to federal grants, are in compliance with grant requirements,
- the department complied with the one-to-one WIC voucher reconciliation requirement, and
- the department adequately monitored local WIC agencies and authorized WIC vendors.

We found the prior-year audit finding had been resolved and we had no findings related to the overall administration of the WIC grant, however, we did note minor weaknesses which have been reported to management in a separate letter.

BLOCK GRANT FOR PREVENTION AND TREATMENT OF SUBSTANCE ABUSE

Our objectives in reviewing this major federal financial assistance program focused on determining whether

- federal funds were spent only for allowable purposes,
- program subcontractors were monitored for compliance with program guidelines,
- the department complied with the maintenance-of-effort requirement, and
- the department complied with regulations concerning the revolving funds for the estab-lishment of homes for recovering substance abusers.

We interviewed key department personnel, reviewed applicable laws, regulations, policies and procedures, and tested representative samples of transactions. We had no findings related to the overall administration of the block grant, however, we did note weaknesses in monitoring (finding 26).

FEDERAL PROGRAMS—NONSPECIFIC

Our objective was to follow-up prior-year findings related to the adequacy of grant payroll cost reallocation and drawdown procedures, federal equipment records, and monitoring of subgrantees.

We reviewed the department's payroll cost reallocation and drawdown procedures. We tested a nonstatistical sample of federally funded equipment purchases to determine whether the grant information (grant number and percentage of federal funds) was entered in the property system. No problems were noted and the first two of the three above findings will not be repeated.

We interviewed key department personnel, reviewed applicable laws and regulations, and obtained an understanding of the department's procedures for monitoring subgrantees and receiving subrecipients' audit reports. Although the department has made some improvements in this area, problems still exist, and the finding (26) is repeated.

26. Monitoring of subgrantees is not adequate

Finding

As noted in the six prior audits, subgrantees of the Department of Health are not adequately monitored. Management concurred with the prior findings, and although improvements have been made, problems continue.

- The Bureau of Alcohol and Drug Abuse Services does not conduct on-site fiscal monitoring reviews of subgrantees and does not have uniform written procedures for fiscal monitoring.
- The files of 80 subrecipients of grants administered by the Department of Health were reviewed for evidence of compliance and fiscal monitoring. The fiscal activities of 32 subrecipients had not been monitored. The programmatic goals and objectives of five subrecipients were not monitored.

Office of Management and Budget (OMB) Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, requires the department to "monitor the activities of subrecipients as necessary to ensure that Federal awards are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts or grant agreements and that performance goals are achieved."

Monitoring also involves obtaining and reviewing subrecipient audit reports, which are prepared by independent CPA firms. Occasionally, these reports contain questioned costs and

indicate amounts due to the state. The department did not meet federal requirements in the following instances:

- Three of the six audit reports reviewed contained questioned costs that were not resolved within six months of receipt of the reports. This resolution process was completed 23 to 122 days after the six-month period ended.
- The department's review of the audit reports did not include following up other reported audit exceptions such as internal control weaknesses.
- Funds were not withheld consistently as follow-up action for subrecipients' not obtaining an audit in accordance with OMB Circular A-133.

Circular A-133 states that it is the recipient's (Department of Health's) responsibility to "follow up and take corrective action on audit findings." Furthermore, it states that "in cases of continued inability or unwillingness to have an audit conducted in accordance with this part, ... pass-through agencies [Department of Health] shall take appropriate action using sanctions such as… withholding a percentage of Federal awards until the audit is completed satisfactorily" or "suspending Federal awards until the audit is conducted."

In addition, the department does not ensure subrecipient audit reports are obtained within six months of the subrecipient's fiscal year-end. The Department of Health's standard contract states:

> The audit contract between the Grantee and the licensed independent public accountant shall be on a contract form prescribed by the Tennessee Comptroller of the Treasury.

The Contract to Audit Accounts states:

> The auditor's report shall be filed prior to _____, but in no case, shall be filed later than six (6) months following the fiscal period to be audited, without prior written explanation to the Comptroller of the Treasury, State of Tennessee and the auditee. The auditor shall file one (1) copy of said report with the Comptroller of the Treasury, State of Tennessee, and with the appropriate officials of the granting agencies . . ..

Thirty-seven of 40 audit reports were not received within six months of the end of the subgrantee's fiscal year as required in the department's standard contract with subgrantees. Reports were received from 19 to 1,048 days after the six-month period. Also, 55 audit reports due as far back as 1994 had not been received as of June 30, 1998.

The department cannot determine compliance with applicable laws and regulations if it does not monitor subrecipients. Additionally, funds could be used for objectives not associated with the grant or contract.

Recommendation

The Commissioner and related bureau directors should establish policies and procedures for annual fiscal monitoring of all subrecipients. Staff should sufficiently document all monitoring and promptly report deficiencies to subrecipients. Significant deficiencies should be reported to the department's Office of Audit and Investigation and to the Comptroller of the Treasury. Recommendations and deficiencies previously noted should be followed up, and this process should also be documented.

All audit exceptions should be followed up and resolved within six months of the receipt of the subrecipients' audit reports. Also, procedures should be developed to ensure subrecipient audit reports are received no later than six months following the subrecipient's year-end. The Commissioner should consider withholding funding from subrecipients when required audits are not conducted or when audit reports are not submitted to the department timely.

Management's Comment

We concur. The Department is in the process of developing a policies and procedures manual for Fiscal Monitoring which includes the annual independent audit and how to handle questioned and disallowed costs and audit findings. Further, the Department is working with the Department of Finance and Administration in the overall contract monitoring program that is being implemented by the Department of Finance and Administration and has submitted a plan for compliance with the program designed by Finance and Administration.

REVENUE

Our objectives in reviewing the revenue controls and procedures focused on determining whether

- departmental controls ensured that transactions were properly supported, that receipts agreed with amounts deposited, that deposit slips were completed properly, that departmental records were reconciled with STARS, and that funds were properly controlled and deposited intact;
- revenue functions were adequately segregated;
- the Department of Finance and Administration's policy for timely deposit of funds received had been followed;
- proper support for journal vouchers was maintained; and
- the department complied with applicable federal rules, regulations, and guidelines when federal funds were involved.

We interviewed key department personnel to gain an understanding of the department's

procedures for and controls over receiving, receipting, controlling, safeguarding, and depositing funds. We also reviewed supporting documentation and tested nonstatistical samples of revenue transactions. Through our interviews and review of records, we found that many of the department's internal controls were not in place as discussed in finding (27).

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27. For the eighth consecutive year, the department's revenue procedures and controls are inadequate

Finding

For the eighth consecutive year, the department's revenue procedures are inadequate. Although improvements have been made, department personnel indicated certain control weaknesses when responding to the internal control questionnaire:

- Health Statistics Information personnel stated that the checks are not restrictively endorsed "For Deposit Only" when the mail is opened. Also, the mail log, cash receipts, and the deposit slip are not compared in a timely manner. It is difficult to determine if funds received were deposited when a comparison is not made. As of May 15, 1998, the March 1998 comparison had not been completed.
- According to personnel at the Bureau of Information Resources, no comparison is made between the mail log, cash receipts, and deposit slip.
- The Health Related Boards personnel stated that checks are not restrictively endorsed, a mail log is not used, and written cash receipts are not prepared when mail is opened. In addition, there is a lack of segregation of duties since the one person who is opening the mail also deposits the funds.
- Fiscal Services, General Environmental Health, and Health Related Boards do not reconcile STARS reports with certifications of deposits promptly.
- In the Children's Special Services clinic of the Northeast regional office, one employee issues receipts and reconciles the cash drawer report.

Recommendation

The Director of Administrative Services should assign staff specific responsibility for ensuring all revenues are properly controlled and should monitor staffs efforts. Written procedures for correctly accounting for receipts, segregating duties, reconciling accounts, preparing receipts or receipt listings, and endorsing revenue items should be developed, implemented, and monitored.

Management's Comment

We concur. Revenue procedures continue to be reviewed periodically with each Bureau by Fiscal Office staff to strengthen internal controls in the collection of the Departments' revenue. Staff will continue to work with each Bureau to address remaining issues relative to collections, deposits and reconciliation with the goal of minimizing the recurrence of issues addressed in the audit finding. The area that continues to have problems relative to timely deposits receives a very high volume of checks daily. We will work with other departments that have similar volumes to minimize deposit and reconciliation problems.

CONTRACTS

Our primary objective in the area of contracts was to follow up prior audit findings to determine whether they had been resolved**.** Our specific objectives were to determine

- whether the department continued to enter into contracts that establish improper employer-employee relationships,
- whether the department allowed contract services to be rendered before proper approvals of the contracts were obtained, and
- whether the department appropriately entered into contracts with community services agencies.

We interviewed key department personnel and reviewed contracts, contract payment support and memorandums. We determined that the prior-year findings relating to contracts with the community services agencies being inconsistent with the Plans of Operation and insufficiently detailed subcontracts for TennCare outreach services were resolved; however, it was noted the department failed to approve contracts timely (finding 29). We also determined that even though improvements have been made the department has continued to enter into con-tracts that create improper employer-employee relationships, as discussed further in finding (28).

28. For the past thirteen years, the department has continued to establish improper employer-employee relationships

Finding

As noted in each audit report since 1986, the Department of Health has entered into contracts with nonprofit organizations, human resource agencies, and community services agencies (CSAs) to assist in implementing the Special Supplemental Food Program for Women, Infants, and Children; Infant Follow-Up Services; Prenatal Services; Community Development;

and other programs. Through these contracts, the department has directed these organizations and agencies to hire and pay certain individuals who are directly supervised by state officials. These contracts apparently create "employer-employee" relationships between the department and these individuals. Management concurred with the finding and improvements are being implemented. However, the department has not corrected the problem.

The practice of allowing employees of non-state entities such as the community services agencies to report directly to Department of Health officials/employees in carrying out what can be construed as state programs raises policy and legal issues. We do not believe that these situations should be accepted as a matter of policy. Additionally it is unclear whether *Tennessee Code Annotated*, Section 37-5-315(2), completely insulates the state from legal liability. The Code states "This part shall not be construed as creating an employer-employee relationship between the department, the community services agencies or their contractors; . . ." This legal concern arises from a review of the factors commonly used in determining the existence of an employer-employee relationship. These factors include, most importantly, an entity's or individual's right to hire and fire and the right to control the performance of a job or work. The recommendation that the Department of Health should consult with the Office of the Attorney General concerning the legal ramifications of such employer-employee relationships has been made for the prior two audits. Management has concurred. However, management has not complied.

In addition, the state apparently has incurred additional cost by contracting with non-state entities to operate programs. Over the years, the CSAs have operated programs for various departments of the state. In addition to direct program costs, the CSAs have received funding from each state department to defray the costs of administration. These costs included the salaries and benefits of the executive director and the fiscal officer, and costs of travel, supplies, and equipment used by the administration staff.

In prior years, the Department of Health provided program funding to the CSAs to be used for a Community Development program, the focus of which was determined by the CSAs with the department approval. However, in fiscal year 1996, the Department of Health transferred the responsibility of the program from the CSAs to the department's regional offices. When the responsibility for the program was transferred back to the department, the state continued to maintain the administrative funding at the same level as in the past. With state personnel operating this program, it would appear that the administrative funding paid to the CSAs would have decreased. However, the Department of Health did not decrease the administrative funding even though the department now controls the hiring and firing of CSA community staff and makes the program decisions. It appears that the cost of administering this program has been shifted to the state rather than being borne by the CSAs.

Recommendation

The Department of Health should not contract with community services agencies, nonprofit organizations, and human resource agencies to establish employer-employee

relationships. Individuals who are in effect performing state services should be placed on the state payroll system through the proper hiring procedures. When appropriate, the department should establish either professional service or personal service contracts. In addition, either complete control of the Community Development program should be returned to the CSAs, or complete fiscal responsibility should be borne by the department. The Department of Health should contact the Office of the Attorney General immediately concerning the legal ramifications of such employer–employee relationships.

Management's Comment

We concur. Complete control of the Community Development program was returned to the Department and the staff placed in department positions. We will continue to review our current contract arrangements relative to functions and responsibilities we have required. In the future, when contracting for outside services, we will evaluate whether this is a function we want the contractor to maintain complete control. If not, we will retain the function within the duties of the Department's personnel.

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29. The department failed to approve contracts before the beginning of the contract period

Finding

The department allowed contract services to be rendered before proper approvals of the contracts were obtained. Nine of 10 contracts reviewed (90%) were not approved until 36 to 58 days after the beginning of the contract period. Chapter 0620-3-3-.04(d)(8) of the Rules of the Department of Finance and Administration states that "upon approval by the Commissioner of Finance and Administration [the contract] shall be an effective and binding contract." If contracts are not approved before the contract period begins and before services are rendered, the state could be obligated to pay for unauthorized services.

The department issues most of their contracts pursuant to departmental grant authorities (DGA). The DGA is sent and approved by the Commissioner of Finance and Administration. Once this approval is obtained, then the Commissioner of Health or her designee can sign the actual contracts. In order to be properly authorized, contracts pursuant to the DGA require the commissioner's signature or that of her designee. All other contracts require the original signature of the commissioner.

In addition, the department's written policies on the preparation and review of contracts and amendments do not contain any deadlines. Without deadlines, the contract period could begin without the contract being properly approved.

Recommendation

The department should develop and implement deadlines to ensure that contracts are properly approved before the beginning of the contract period. Contracts should be approved by proper departmental personnel before the beginning of the contract period. Procedures should include regular monitoring of the contracting process by supervisory staff to ensure compliance.

Management's Comment

We concur. The Office of Budget and Finance works with program staff each year to encourage early submission of contracts for review and signature. However, delays do occur and there are instances where contracts have been signed after the begin date of the contract period. We will continue to encourage procedures that will strive toward the execution of Department contracts prior to the beginning date of the contract period. Notices are being sent to each Bureau outlining necessary deadlines to ensure contracts are in effect on or before the start date of the contract. We will monitor contracts as they are processed and notify each Bureau of those contracts that are received that do not allow sufficient time for signatures prior to the begin date.

SUPPLEMENTAL PAY

Our work in the area of supplemental pay consisted of following up a prior audit finding to determine whether the problem had been resolved. Our objective was to determine whether the department had ensured that all supplemental pay recipients met department and *Tennessee Code Annotated* eligibility requirements.

We interviewed key department personnel to gain an understanding of the department's supplemental payroll system and its evolution. We also reviewed department policies, *Tennessee Code Annotated* (Section 68-2-603), supplemental pay records, and memorandum agreements with the counties. We found the department had discontinued inappropriately increasing the number of employees receiving supplemental pay but had not corrected all previously noted inappropriate supplemental pay to ineligible employees. This issue is discussed in Past Findings Not Acted Upon by Management.

CONTINGENT AND DEFERRED REVENUE

Our objectives in reviewing contingent and deferred revenue controls and procedures and subaccount balances focused on determining whether

- contingent/deferred revenue accounts were used for the intended purpose,
- transactions were properly supported,

- only applicable items were recorded as contingent or deferred revenue and in the proper amounts,
- revenue was transferred from contingent/deferred to earned when the applicable criteria were met,
- the department had complied with applicable federal rules, regulations, and guidelines when federal funds were involved, and
- large variances between current and prior-year ending balances could be reasonably explained.

We interviewed key department personnel to gain an understanding of the department's procedures for and controls over deposits into the subaccounts and transfers of earned revenue. We reviewed supporting documentation and tested nonstatistical samples of transactions. We also compared June 30, 1998, subaccount balances with balances reported at June 30, 1997, and obtained explanations for significant variances. We had no findings related to contingent and deferred revenue.

DEPARTMENT OF FINANCE AND ADMINISTRATION POLICY 20, "RECORDING OF FEDERAL GRANT EXPENDITURES AND REVENUES"

Department of Finance and Administration Policy 20 requires that state departments whose financial records are maintained on the State of Tennessee Accounting and Reporting System (STARS) fully utilize the STARS Grant Module to record the receipt and expenditure of all federal funds. Our objectives focused on determining whether

- appropriate grant information was entered into the STARS Grant Control Table upon notification of the grant award, and related revenue and expenditure transactions were coded with the proper grant codes;
- appropriate payroll costs were reallocated to federal programs within 30 days of each month-end using an authorized redistribution method;
- the department made drawdowns at least weekly using the applicable STARS reports;
- the department had negotiated an appropriate indirect cost recovery plan, and indirect costs were included in drawdowns, and
- the department used the appropriate STARS reports as bases for preparing the Schedule of Expenditures of Federal Awards and reports submitted to the federal government.

We interviewed key personnel to gain an understanding of the department's procedures and controls concerning Policy 20. We reviewed supporting documentation and tested nonstatistical samples of grant awards, revenue and expenditure transactions, drawdowns, and reports submitted to the federal government. We also reviewed payroll cost reallocations and the

schedule of expenditures of federal awards. We found that the department had resolved audit finding regarding inadequate grant payroll cost reallocation and drawdown procedures. However, other minor weaknesses were noted which have been reported to management in a separate letter.

OBSERVATIONS AND COMMENTS

TITLE VI OF THE CIVIL RIGHTS ACT OF 1964

Tennessee Code Annotated, Section 4-21-901, requires each state governmental entity subject to the requirements of Title VI of the Civil Rights Act of 1964 to submit an annual Title VI compliance report and implementation plan to the Department of Audit by June 30, 1994, and each June 30 thereafter. For the year ending June 30, 1998, the Department of Health filed its compliance report and implementation plan on July 1, 1997. For the year ended June 30, 1998, the Bureau of TennCare filed its compliance report and implentation plan on July 15, 1997.

Title VI of the Civil Rights Act of 1964 is a federal law. The act requires all state agencies receiving federal money to develop and implement plans to ensure that no person shall, on the grounds of race, color, or origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal funds.

The State Planning Office in the Executive Department was assigned the responsibility of serving as the monitoring agency for Title VI compliance, and copies of the required reports were filed with the State Planning Office for evaluation and comment. However, the State Planning Office has been abolished. The Office of the Governor has not designated a new monitoring agency for the Executive Branch.

A summary of the dates state agencies filed their annual Title VI compliance reports and implementation plans is presented in the special report, *Submission of Title VI Implementation Plans*, issued annually by the Comptroller of the Treasury.

OIR OVERCHARGES

The Office for Information Resources (OIR) in the Department of Finance and Administration continues to charge the Department of Health for leased computer equipment the department no longer has. Despite the requests by the department to stop the charges, OIR continues to automatically charge the department's allotment codes and cost centers for this surplused equipment each month, using front-end billing journal vouchers. Because OIR's detailed list of charges did not list equipment tag numbers before June 1995, the department could not determine precisely what equipment it was being billed for each month. OIR made changes to the billing format to include tag numbers; however, Department of Health personnel determined that the tag numbers used are not always accurate.

OIR changed its billing format again after June 30, 1996, and stated in a memorandum that even though "there are several changes in the billing processes,…there is still a lot of work to be done to complete the reporting and to provide…access to the detail information." OIR continues to charge the department for equipment it does not have and has made no attempt to reimburse the department for the excess charges.

Some of the allotment codes and costs centers automatically charged by the monthly front-end billing journal vouchers are used exclusively for federal grants, and some have been charged for a portion of the surplused equipment. Because the department could not isolate these costs, it was unable to determine which grants and what amounts were charged and are still being charged. According to Office of Management and Budget, Circular A-87, "Cost Principles for State and Local Governments," charges must be "necessary and reasonable for proper and efficient administration of the grant program." The department, therefore, may face questioned costs for these equipment charges.

SPECIAL INVESTIGATION

On February 1, 1999, the Division of State Audit released a Special Report on allegations that TennCare Bureau staff had improperly made changes to an external survey report. The review determined that during April and May 1998, TennCare Bureau staff did review a draft of the First Health's External Quality Review Organization's (EQRO's) draft focus survey report on Tennessee Behavioral Health, Inc. (TBH). TennCare Bureau staff did suggest changes to First Health staff. First Health staff agreed with the changes and adopted them in the final version of the focus survey.

A comparison of the draft focus survey report with the final report disclosed that some of the revisions in question could reasonably be considered by third party readers to materially alter the meaning of five of the sixty-one findings with regard to shortcomings of the TennCare Bureau, TBH, and the TennCare Partners Program. Although the revisions may have given the appearance of deliberate changes to a draft report to deflect criticism from the TennCare Bureau, no direct corroborative evidence was found to support the allegations that these changes were outside the boundaries of the contract, were intentionally deceitful, or the result of undue influence. The concerns of the appropriate structure for external reporting, the intended readership and scope of the surveys, and the extent to which surveyors should focus on quality of care were discussed in the Special Report.

APPENDIX

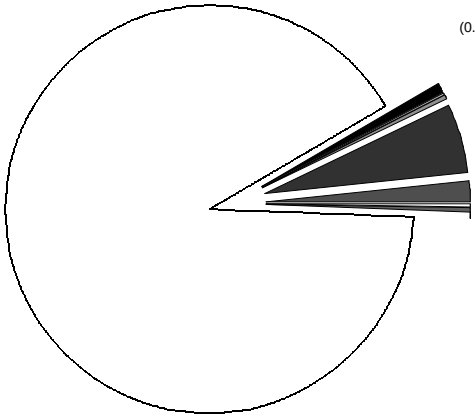
DIVISIONS AND ALLOTMENT CODES

Department of Health divisions and allotment codes:

343.01 Executive Administration
343.03 Office of Budget and Finance
343.04 Bureau of Information Systems
343.05 Bureau of Health Care Facilities
343.07 Emergency Medical Service
343.08 Laboratory Services
343.10 Health Related Boards
343.39 Environmental Sanitation
343.44 Bureau of Alcohol and Drug Abuse Services
343.45 Communicable Health Services
343.47 Maternal and Child Health
343.49 Communicable and Environmental Disease Services
343.52 Health Promotion and Protection
343.53 WIC Supplemental Foods
343.60 Aid to Local Health Units
343.65 TennCare Administration
343.66 TennCare Services
343.67 Waivers and Crossover Services
343.68 Long-Term Care Services
343.70 Nursing Home Grant Assistance Program

Expenditures by Allotment & Division

Fiscal Year Ended June 30, 1998 (Unaudited)



(0.80%) Bureau of Alcohol and Drug Abuse Services
31,781,854

(0.13%) Bureau of Information Resources
4,970,011

(0.34%) Bureau of Manpower and Facilities
13,494,658

(5.5%) Bureau of Health Services
217,187,286

(1.65%) Executive Administation
64,993,081

(0.24%) LabortoryServices
9,403,552

(0.34%) Bureau of Administrative Services
13,222,838

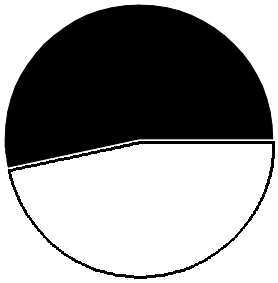
(91.00%) Bureau of TennCare
3,591,864,547

Source: Department of Health

General Fund Expenditures

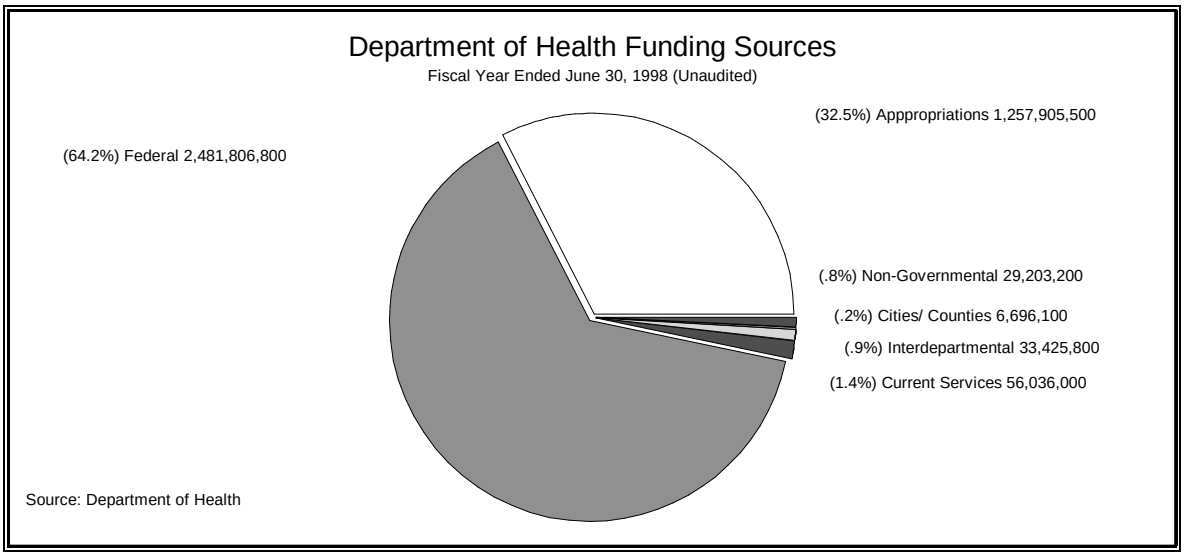
Fiscal Year Ended June 30, 1998 (Unaudited)

(52.8%) Tennessee Department of Health
3,908,393,779



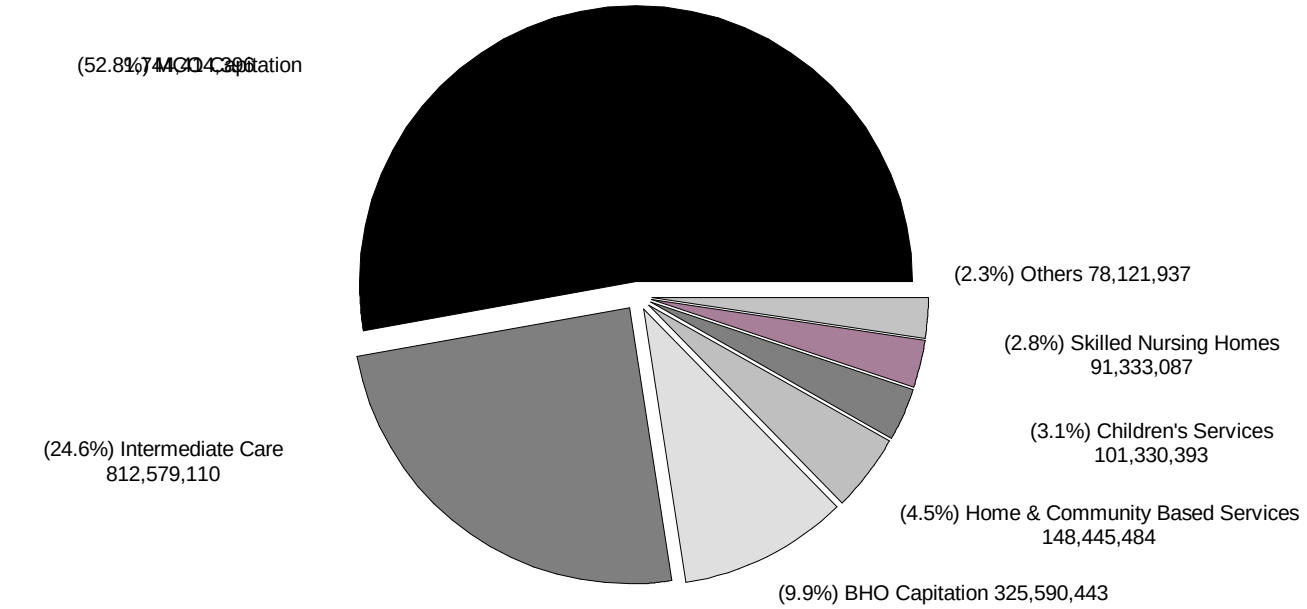
(47.2%) Other Departments
3,491,234,128

Source: Department of Health


Department of Health Funding Sources
Fiscal Year Ended June 30, 1998 (Unaudited)
(32.5%) Apppropriations 1,257,905,500
(64.2%) Federal 2,481,806,800
(.8%) Non-Governmental 29,203,200
(.2%) Cities/ Counties 6,696,100
(.9%) Interdepartmental 33,425,800
(1.4%) Current Services 56,036,000
Source: Department of Health

TennCare Dollars Paid by Claim Type

For Year Ended June 30, 1998 (Unaudited)



Source: Bureau of TennCare